

Foreigner's Report



The House of Representatives today passed a bill that would allow foreign-born workers to remain in the United States if they have been employed here for at least five years. The bill, known as the "Alien Worker Protection Act," would also require employers to verify the identity and employment status of foreign workers. The bill was passed by a vote of 218 to 205. The bill would allow foreign-born workers to remain in the United States if they have been employed here for at least five years. The bill would also require employers to verify the identity and employment status of foreign workers. The bill was passed by a vote of 218 to 205.

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Monday, November 25, 1991

This section of the FEDERAL REGISTER contains regulatory documents having general applicability and legal effect, most of which are keyed to and codified in the Code of Federal Regulations, which is published under 50 titles pursuant to 44 U.S.C. 1510. The Code of Federal Regulations is sold by the Superintendent of Documents. Prices of new books are listed in the first FEDERAL REGISTER issue of each week.

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

7 CFR Part 318

[Docket No. 91-139]

Papayas From Hawaii

AGENCY: Animal and Plant Health Inspection Service.

ACTION: Final rule.

SUMMARY: We are amending the "Hawaiian Fruits and Vegetables" regulations to remove the "double hot water dip" as an approved quarantine treatment for papayas intended for movement from the State of Hawaii to other parts of the United States. This action is necessary to reduce the risk of the spread of pests that are not widely prevalent or distributed within and throughout the United States.

EFFECTIVE DATE: July 1, 1992.

FOR FURTHER INFORMATION CONTACT: David R. Reeves, Operations Officer, Port Operations, PPQ, APHIS, USDA, Room 635, Federal Building, 6505 Belcrest Road, Hyattsville, MD 20782, 301-436-8295.

SUPPLEMENTARY INFORMATION:

Background

The regulations regarding fruits and vegetables from Hawaii (contained in 7 CFR 318.13 through 318.16 and referred to below as the regulations), quarantine the State of Hawaii and regulate the interstate movement from Hawaii of, among other things, papayas in a raw or unprocessed state. The regulations require, as a condition of interstate movement from Hawaii, that papayas be treated with an approved treatment specified in the regulations. The approved treatments destroy the life stages of the Mediterranean fruit fly (*Ceratitis capitata* (Wied.)), the melon

fly (*Dacus cucurbitae* (Coq.)), and the Oriental fruit fly (*Dacus dorsalis* (Hendel.)). The fruit flies, commonly referred to as "Trifly," infest Hawaii but not the rest of the United States.

On August 13, 1991, we published in the Federal Register a proposed rule (56 FR 38351-38352, Docket No. 91-077), in which we proposed to remove the double hot water dip treatment as an approved treatment for papayas from Hawaii. We solicited comments concerning the proposed rule for a 30-day comment period ending September 12, 1991, and received 7 comments during that period. The commenters included a State department of agriculture, a papaya industry association, and five members of the Hawaiian processing and packing industry. One commenter supported the proposed rule as written. Two commenters requested that elimination of the double hot water dip treatment not be made effective until July 1992. Another commenter requested that the proposed regulations not be made effective until February 1993. One commenter recommended in general that the Hawaiian papaya industry be allowed as much time as necessary to convert to alternative methods of treatment.

All of the commenters requesting a specific delay in the effective date are members of the Hawaiian processing and packing industry. None of these commenters presented objections to the proposal itself, but each stated that additional time is necessary to make operational the equipment needed for alternative methods of treatment.

Two other commenters, both members of the Hawaiian processing and packing industry, stated that implementation of the proposed provisions should not be delayed. These commenters indicated that their own facilities would be able to use an alternative method of treatment by January 1992, and that it would be unfair to provide other facilities additional time to convert.

We recognize that acquiring, installing, and testing alternative treatment systems can require a significant amount of time and a substantial investment, and agree that affected facilities should be given a reasonable period to convert to these systems. Based on the information available to us regarding the time

necessary to install new systems, we consider the period through June 30, 1992, to be sufficient for facilities to convert to alternative methods of treatment. We are therefore making the provisions of this final rule effective as of July 1, 1992.

Both of the commenters who opposed a delay in implementation of the proposed regulations stated that an extended delay would cause an unacceptable pest risk. In our proposal, we stated that, although the double hot water dip treatment is effective when carried out as approved, we frequently have insufficient personnel to monitor each step of the treatment to ensure that all safeguards are maintained. That situation would continue to be the case if the double hot water dip were retained indefinitely as an approved treatment. However, based on our experience monitoring the Hawaiian papaya industry and on comments received, we have determined that certain of the treatment facilities in Hawaii, in anticipation of an eventual removal of the double hot water dip as an approved treatment, will have the capability to use alternative treatments by early 1992. With this reduction in the use of the double hot water dip treatment, we are confident we will be able to monitor adequately those facilities still using the treatment during the time it will take them to convert to alternative treatments.

One of the commenters opposing a delay stated that, during the last 4 years, close to 117,000 live fruit fly larvae have been entered into the United States as a result of our allowing the double dip hot water treatment, and that any delay in eliminating the treatment would therefore be unacceptable. We do not agree. As we noted in our proposal, quality control inspections have twice discovered fruit flies that appear to have survived the double hot water dip treatment, possibly due to our inability to monitor each step of the process. While these incidences represent an unacceptable pest risk, they do not suggest that a large number of fruit flies are moving interstate from Hawaii due to our allowing the treatment. As we discussed above, we are confident of our ability to adequately monitor the treatment through June 30, 1992.

Comments Addressing the Economic Impact of the Proposed Rule

One commenter disagreed with certain of the data we included in our discussion of the potential economic impact of the proposed provisions. In our proposal, we projected that each Hawaiian papaya treatment facility that converts to alternative means of treatment would realize an annual savings of between \$106,950 and \$191,800, due to lower per unit costs for treatment. We stated that part of this savings would result from elimination of the need for State inspection and fruit sorting before treatment of the papayas. The commenter stated that we overestimated this savings, because State inspectors would continue to carry out inspections as part of a Hawaiian "grade and size" inspection program.

In assessing the potential savings to the Hawaiian papaya industry from the proposed provisions, we considered those costs that are the result of APHIS regulations. By eliminating the need to inspect for degree of ripeness, we are eliminating a regulatory cost. We view this cost reduction as being separate from the issue of whether State inspectors might continue to carry out inspections for other reasons.

In our proposal, we stated that the need to convert to alternative treatment methods would require four papaya quarantine treatment facilities in Hawaii to install new treatment units. We based our estimate of total cost to the industry on this number of new units. One commenter disagreed with our projection that four new units would be necessary and estimated instead that at least eight new units would be required. We acknowledge that total costs to the industry would be higher than we projected if a company chooses to construct more than one dual treatment facility, and we have included a statement to that effect in our discussion of Executive Order 12291 and the Regulatory Flexibility Act in this document.

The same commenter disagreed with data we published in our proposed rule regarding the amount of fresh papaya shipped from Hawaii to the United States mainland in 1990. The commenter submitted different data based on shipment records taken from inspection certificates from the Federal/State Inspection Service of the Hawaii Department of Agriculture. The data we published was supplied by the United States Department of Commerce. In order to accommodate the difference between the information from the two sources, in this document we use a

range to indicate the amount of papaya shipped and related data.

Executive Order 12291 and Regulatory Flexibility Act

We are issuing this rule in conformance with Executive Order 12291, and we have determined that it is not a "major rule." Based on information compiled by the Department, we have determined that this rule will have an effect on the economy of less than \$100 million; will not cause a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; and will not cause a significant adverse effect on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

In 1990, between 19.8 and 24.9 million pounds of Hawaiian papayas were shipped to the United States mainland, representing between 34.2 and 43.2 percent of total Hawaiian papaya production, with an estimated value of between \$4.9 and \$6.6 million.

Seven companies currently operate papaya quarantine treatment facilities in Hawaii. Three of these companies do not use the double hot water dip treatment and will not be impacted by the rule change. The remaining four companies currently use the double hot water dip treatment method, two of them exclusively. We expect these companies to replace their double hot water dip facilities with units that have the capability to treat papayas with both the vapor heat treatment specified in 7 CFR 318.13-4b and the high temperature forced air treatment specified in the Plant Protection and Quarantine Treatment Manual. Having access to a unit with vapor heat capabilities is an added advantage, because vapor heat is the only quarantine treatment approved by Japan for fresh papaya shipments to that country. The dual units are less costly to construct and more cost efficient to operate than units for irradiation, the other approved treatment, specified in 7 CFR 318.13-4g, for papayas from Hawaii.

The estimated cost of constructing a new dual facility will range between \$200,000 and \$300,000. The actual price will vary depending on location and treatment capacity. Therefore, the total cost of construction will range between approximately \$0.8 million and \$1.2 million for the Hawaiian papaya industry. Total construction costs will be higher if a company chooses to

construct more than one dual treatment facility.

Conversely, in the long run the Hawaiian papaya industry will benefit from lower treatment costs, including lower labor expenditures for inspection, by converting to dual facilities. Only papayas $\frac{1}{4}$ or less ripe may be treated with the double hot water dip method. This requires that labor be hired to sort papayas into groups according to a "ripeness index." At present, State inspectors monitor industry compliance with the ripeness index. With the elimination of the double hot water dip method, State inspection and fruit sorting will no longer be necessary to monitor compliance with the ripeness index. However, Federal inspection and monitoring will still be required during and after treatment and prior to shipment to the mainland. We estimate that each company that converts to a dual facility will realize an annual savings of between \$106,950 and \$191,800 over the use of the "double hot water dip" treatment. Assuming a discount rate of 10 percent to perpetuity, the companies we expect to convert to a dual facility will be expected ultimately to save between \$1,069,500 and \$1,918,000 over their current treatment costs.

The cost of the rule change will be approximately \$8,200 to \$193,050 in the first year per company that builds a dual facility. This represents the construction costs of new quarantine treatment facilities, minus approximately \$106,950 to \$191,800 in first-year savings due to lower per unit treatment costs. In the long-run, construction costs for new quarantine treatment facilities will be offset by savings generated by the reduced per unit cost of quarantine treatment.

Under these circumstances, the Administrator of the Animal and Plant Health Inspection Service has determined that this action will not have a significant economic impact on a substantial number of small entities.

Paperwork Reduction Act

This rule contains no new information collection or recordkeeping requirements under the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 *et seq.*).

Executive Order 12372

This program/activity is listed in the Catalog of Federal Domestic Assistance under No. 10.025 and is subject to Executive Order 12372, which requires intergovernmental consultation with State and local officials. (See 7 CFR part 3015, subpart V.)

List of Subjects in 7 CFR Part 318

Agricultural commodities, Guam, Hawaii, Plant diseases, Plant pests, Plants (Agriculture), Puerto Rico, Quarantine, Transportation, Virgin Islands.

Accordingly, we amending 7 CFR part 318 as follows:

PART 318—HAWAIIAN AND TERRITORIAL QUARANTINE NOTICES

1. The authority citation for part 318 continues to read as follows:

Authority: 7 U.S.C. 150bb, 150dd, 150ee, 150ff, 161, 162, 164a, 167; 31 U.S.C. 9701; 7 CFR 2.17, 2.51, and 371.2(c).

§ 318.13-1 [Amended]

2. In part 318, Subpart—Hawaiian Fruits and Vegetables, § 318.13-1, the definition of "Compliance agreement" is amended by removing the references to "§ 318.13-4g" and "§ 318.13-4h" and by adding in their place references to "§ 318.13-4f" and "§ 318.13-4g", respectively.

§ 318.13-4f [Removed]

§§ 318.13-4g, 318.13-4h [Redesignated as §§ 318.13-4f and 318.13-4g]

3. In part 318, Subpart—Hawaiian Fruits and Vegetables, § 318.13-4f is removed and §§ 318.13-4g and 318.13-4h are redesignated as §§ 318.13-4f and 318.13-4g, respectively.

Done in Washington, DC, this 20th day of November 1991.

Robert Melland,

Administrator, Animal and Health Inspection Service.

[FR Doc. 91-28278 Filed 11-22-91; 8:45 am]

BILLING CODE 3410-34-M

Agricultural Stabilization and Conservation Service**7 CFR Part 780****Appeal Regulations**

AGENCIES: Agricultural Stabilization and Conservation Service and Commodity Credit Corporation, USDA.

ACTION: Interim rule.

SUMMARY: This interim rule implements changes made by the Food, Agriculture, Conservation, and Trade Act of 1990 (the Act), (enacted November 28, 1990) which amended Title IV of the Agricultural Act of 1949 with respect to the Agricultural Stabilization and Conservation Service (ASCS) administrative appeals process. This rule amends the ASCS appeal regulations at 7 CFR part 780 to: (1) Provide for the establishment of a

National Appeals Division (NAD) within the ASCS; (2) establish the authority for the director of NAD to issue final appeal determinations; and (3) provide specific procedures for filing requests for reconsideration and appeals to county and State Agricultural Stabilization and Conservation (ASC) Committees (county and State committees) and NAD.

DATES: *Effective date:* This interim rule shall be effective November 25, 1991. Comments must be received on or before December 26, 1991 in order to be assured consideration.

ADDRESSES: Send comments on this interim rule to Director, Appeals Staff, Agricultural Stabilization and Conservation Service, United States Department of Agriculture, PO Box 2415, Washington, DC 20013. All written submissions made pursuant to this rule will be available for further inspection in room 2741, South Building, USDA, between the hours of 8:15 a.m., and 4:45 p.m. Monday through Friday.

FOR FURTHER INFORMATION CONTACT: Carolyn A. Burchett, Director, Appeals Staff, Agricultural Stabilization and Conservation Service, United States Department of Agriculture, PO Box 2415, Washington, DC 20013. Telephone: (202) 720-5533.

SUPPLEMENTARY INFORMATION: This interim rule has been reviewed under USDA procedures which implement Executive Order 12291 and Departmental Regulation No. 1512-1 and has been classified as "not major." It has been determined that this notice will not result in: (1) An annual effect on the economy of \$100 million or more; (2) major increases in costs or prices for consumers, individual industries, Federal, State or local Government agencies, or geographic regions; or (3) significant adverse effects on competition, employment, investment, productivity, innovation or on the ability of United States-based enterprises in domestic or export markets.

The Executive Vice President of CCC (Administrator of ASCS) certifies that this rule will not have a significant impact on a substantial number of participating individuals and entities because the procedure set out in this rule would not increase, but would decrease, the time and paperwork necessary to process an appeal.

It has been determined by an environmental evaluation that this action will have no significant impact on the quality of the human environment. Therefore, neither an Environmental Assessment nor an Environmental Impact Statement is needed.

This program/activity is not subject to the provisions of Executive Order 12372

which requires intergovernmental consultation with State and local officials. See Notice related to 7 CFR part 3015, subpart V, published at 48 FR 29115 (June 24, 1983).

The information collections required by this rule have been approved for use through September 30, 1994, by the Office of Management and Budget, and assigned OMB No. 0560-0137. Public reporting burden for these collections is estimated to average 2 hours per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing the burden, to the Department of Agriculture, Clearance Officer, OIRM, Room 404-W, Washington, DC 20250; and to the Office of Management and Budget, Paperwork Reduction Project (OMB No. 0560-0137), Washington, DC 20503.

This interim rule is effective upon publication in the *Federal Register* since the changes made by this rule will provide enhanced administration of the ASCS appeal system without adverse impact on affected parties. However, comments are requested and will be taken into consideration in developing the final rule.

BACKGROUND: Section 8(b) of the Soil Conservation and Domestic Allotment Act, as amended (16 U.S.C. 590h(b)), provides for the establishment of "local and State committees" to be used in carrying out the provisions of that act. These local committees are commonly referred to as county committees. County and State committees have been used extensively in the past to implement various other programs that are conducted by CCC and the Department of Agriculture, including the price support and production adjustment programs of CCC. The method for selecting these committees and their general duties are set forth at 7 CFR part 7.

A major function of county and State committees is to serve as a decision making and reviewing authority with respect to the implementation and administration of the various conservation, price support, and production adjustment programs. Included in this function is the participation of county and State committees in the administrative appeal process that is made available to producers who believe that an erroneous determination concerning their participation in such a program has

been made. The administrative appeal process is set forth at 7 CFR part 780. These regulations provide that if a producer is dissatisfied with the initial determination by either the county or State committee such producer may request that the determination be reconsidered by the authority which issued the initial determination. If the producer is dissatisfied with this subsequent determination, an appeal may be filed with the next higher reviewing authority. Under the previous regulation the Deputy Administrator, State and County Operations (DASCO), was the final reviewing authority.

Under this interim rule an appeal determination of a State committee or an initial determination rendered by DASCO, or any other employee or agent of ASCS or CCC, may be appealed to NAD which constitutes the final level of appeal.

Throughout this appeal procedure, the producer pursuing the appeal is entitled to an informal hearing. Upon appeal the appropriate county or State committee or NAD will convene a hearing in which the appellant is provided the opportunity to present relevant facts and evidence.

This interim rule amends 7 CFR part 780 in several respects for clarity and deletes obsolete references. This interim rule also makes editorial changes to all sections of 7 CFR part 780 and reorganize the information in a more logical sequence. The following is a summary of the major amendments made by this interim rule.

Section 780.1 is amended to conform to changes required under the Act and establish the effective date for changes required in the appeal process.

Section 780.2 is amended to specify that the provisions of this part are applicable to any determinations made by county or State committees, DASCO and any other employee or agent of ASCS or CCC. Appealable issues are also specified in this section.

Section 780.3 is expanded to include additional definitions for terminology used in this part, including new definitions for changes required under the Act.

Section 780.4 through 780.6 are reserved for future use.

Section 780.7 provides for reconsideration by a county committee, appeal of the county committee determination to the State committee, and reconsideration by the State committee.

Section 780.8 is added to specify conditions under which an appeal may be filed with NAD.

Section 780.9 specifies the general procedure for appeal hearings before the county and State committees and NAD.

Section 780.10 through 780.14 are reserved for future use.

Sections 780.15 and 780.16 specify the applicable time limitations and requisite form for filing an appeal.

Section 780.17 sets forth the purpose and effect of appeal determinations by either the county or State committee or NAD. Section 780.17 also specifies those technical decisions and determinations based on mathematical calculations which are not appealable.

Section 780.18 specifies when a hearing can be reopened at the discretion of ASCS for good cause.

Section 780.19 is added to specify the additional requirements for proceedings for appeals to NAD included in the Act with respect to the duties and responsibilities of the Director, including the authority to, if appropriate, require the attendance of witnesses and production of documentary evidence by subpoena. This section also specifies the authority of the Director to issue final determinations.

Section 780.20 is added to specify the conditions under which a participant may request the Director of NAD to subpoena attendance of witness or production of documentary evidence.

Sections 780.21 and 780.22 are reserved for future use.

Section 780.23 essentially restates the authority of the Administrator of ASCS or the Executive Vice President of CCC to review and in any way modify any determination by a county or State committee. New provisions are included in this section to allow either the Administrator of ASCS or the Executive Vice President of CCC the authority to review and in any way modify determinations by the Director of NAD.

List of Subjects in 7 CFR Part 780

Administrative practices and procedures.

Interim Rule

Accordingly, 7 CFR part 780 is revised to read as follows:

PART 780—APPEAL REGULATIONS

Sec.

780.1 General statement.

780.2 Applicability.

780.3 Definitions.

780.4–780.6 [Reserved].

780.7 Reconsideration and appeals with county and State committees.

780.8 Appeal to National Appeals Division.

780.9 Appeal hearing procedure.

780.10–780.14 [Reserved].

780.15 Time limitations for filing requests for reconsideration or appeals.

Sec.

780.16 Form of request for reconsideration or appeal.

780.17 Determination.

780.18 Reopening of hearing.

780.19 Procedure for appeals to the National Appeals Division.

780.20 Participant request for exercise of subpoena powers.

780.21–780.22 [Reserved].

780.23 Delegation of authority.

780.24 OMB-control numbers assigned pursuant to the Paperwork Reduction Act.

Authority: 7 U.S.C. 1433e; 15 U.S.C. 714b and 714c; 16 U.S.C. 590h.

§ 780.1 General statement.

This part sets forth the regulations to provide for an administrative appeal process for adverse determinations issued with respect to programs which are administered by the Agricultural Stabilization and Conservation Service (ASCS). These programs also include programs administered by ASCS on behalf of the Commodity Credit Corporation (CCC) and are generally set forth in Chapters VII and XIV of this title. This part also establishes the National Appeals Division (NAD) within ASCS which will administer the provisions of this part. This part is applicable to any adverse determination made by any State or county Agricultural Stabilization and Conservation Committee (county committee and State committee respectively) or personnel of ASCS or agents of CCC after November 28, 1990, which has not otherwise become final by November 25, 1991. The resolution of appeals made with respect to all other determinations shall be made in accordance with the regulations set forth in this part as of November 22, 1991.

§ 780.2 Applicability.

(a) The regulations contained in this part are applicable to determinations made by county and State committees, any other personnel of ASCS or by agents of CCC, except as otherwise may be provided in individual program requirements. These regulations prescribe the rules and procedure that must be followed by a person who seeks reconsideration or review of a determination made with respect to:

(1) Denial of participation in such a program;

(2) Compliance with program requirements;

(3) The making of payments or other program benefits to a person who is a participant in such a program; and

(4) The making of payments or other program benefits to a person who is not a participant in such a program.

(b) Reconsideration and review under this part are limited to individual program determinations made with respect to those persons meeting the requirements of paragraph (a) of this section. Accordingly, there is no right to reconsideration or review under this part with respect to general program requirements which are applicable to all program participants or producers.

§ 780.3 Definitions.

Appeal means a written request by a participant asking the next level reviewing authority to review an adverse determination.

CCC means Commodity Credit Corporation, a wholly-owned Government corporation within the U.S. Department of Agriculture.

County committee means an ASC county committee established in accordance with section 8(b) of the Soil Conservation and Domestic Allotment Act (16 U.S.C. 590h(b)).

DASCO means the Deputy Administrator, State and County Operations, of ASCS.

Director means the director of NAD.

Hearing means an informal proceeding to afford a participant the opportunity to present testimony or documentary evidence or both to have a previous determination reversed and to show why an adverse determination was not proper. Hearings may include compulsory attendance of witnesses, compulsory production of documentary evidence, and the administering of oaths and affirmations if, upon a showing of good cause by the participant, the Director of NAD or other delegated authority determines such requirement is necessary.

Hearing Officer means an individual who is an employee of NAD and assigned the responsibility of conducting a hearing for an individual appeal filed by a participant with the Director or other appropriate official in accordance with this part.

Initial Determination means the first program determination which adversely impacts a program participant as provided in § 780.2.

NAD means the National Appeals Division, the ASCS division established for the purpose of hearing and reviewing producer appeals under this part.

Participant means any individual or entity whose right to participate in, or receive payments or other benefits in accordance with, any of the programs to which these regulations apply is affected by a determination of any county committee, State committee, employees or agents of such committees, other personnel of ASCS, or agents of CCC. An authorized representative of

the participant shall be considered to be a participant.

Reconsideration is a subsequent consideration of a prior determination by the same reviewing authority who issued the prior determination.

State committee means an ASC State committee established in accordance with section 8(b) of the Soil Conservation and Domestic Allotment Act (16 U.S.C. 590h(b)) including, insofar as is practical, the Director of the Caribbean Area ASCS office for Puerto Rico and the Virgin Islands.

Verbatim Transcript is an official, written record of proceedings in a hearing which has been transcribed by a court reporter whose appearance is arranged for in accordance with these regulations.

§ § 780.4-780.6 [Reserved]

§ 780.7 Reconsideration and appeals with the county and State committees.

(a) Any participant may obtain a reconsideration of a determination made by a county committee or an employee of the county committee and an informal hearing on such determination by filing a written request for reconsideration with the county committee if the participant believes:

- (1) The initial determination was not proper and not made in accordance with applicable program regulations; or
- (2) That all of the facts were not considered with respect to such determination.

(b) Any participant who believes that a proper determination has not been made by the county committee upon its reconsideration of an initial determination may obtain a review of the county committee determination by the State committee and an informal hearing in connection therewith by filing a written appeal with the State committee.

(c) Any participant may obtain a reconsideration of a determination made by a State committee or an employee of the State committee and an informal hearing on such determination by filing a written request for reconsideration with the State committee if the participant believes:

- (1) The initial determination was not proper and not made in accordance with applicable program regulations; or
- (2) That all of the facts were not considered with respect to such determination.

§ 780.8 Appeal to National Appeals Division.

Any participant who believes that a determination rendered by the State committee under § 780.7 or an initial determination rendered by any

employee or agent of the ASCS national offices or CCC was not proper, may obtain a review by NAD of such determination and an informal hearing by filing a written appeal with NAD except as provided in §§ 780.2 and 780.17.

§ 780.9 Appeal hearing procedure.

(a) The hearing shall be held at the time and place designated by the reviewing authority.

(b) The hearing shall be conducted by the reviewing authority, or a representative of the reviewing authority, in the manner determined by CCC or ASCS to most likely obtain the facts relevant to the matter at issue. The reviewing authority may confine the presentation of facts and evidence to pertinent matters and may exclude irrelevant, immaterial, or unduly repetitious evidence, information, or questions.

(c) When the participant requests copies of documents, information, or evidence upon which a determination is made or which will form the basis of the determination, copies of all program documents, information or evidence, including minutes from county committee or State committee proceedings, shall be made available to the participant.

(d) The reviewing authority shall prior to the hearing prepare a written record which contains a clear, concise statement of the facts as asserted by the participant and material facts found by the reviewing authority. The names of interested individuals appearing at the hearing shall be included.

(e) A verbatim transcript of the hearing may be made if: (1) The participant requests, within a reasonable period prior to the hearing, that the reviewing authority arrange for such a transcript and agrees to pay the expense thereof; or

(2) The reviewing authority determines that such a transcript is appropriate.

(f) Unofficial recording of a hearing by a voice recorder or an unauthorized court reporter is prohibited.

(g) The participant shall be given a full opportunity to present facts and information relevant to the matter at issue and may present oral or documentary evidence. At its discretion, the reviewing authority may request or permit individuals other than those appearing on behalf of the participant to present information or evidence at such hearing and, in such event, permit the participant to question such individuals.

(h) If at the time scheduled for the hearing the participant is absent and no

appearance is made on behalf of the participant or no arrangements have been made for rescheduling the hearing, the reviewing authority shall, after a reasonable time, conclude the hearing or may, at its discretion, accept information and evidence submitted by other individuals present at the hearing.

§§ 780.10-780.14 [Reserved]

§§ 780.15 Time limitations for filing requests for reconsideration or appeals.

(a) A request for reconsideration of a prior determination by the same reviewing authority or an appeal for review of a determination made by a lower reviewing authority shall be filed within 15 days after written notice of the determination which is the subject of such request or appeal is mailed to or otherwise made available to the participant. A request for reconsideration or appeal shall be considered to have been "filed" when personally delivered in writing to the appropriate reviewing authority or when postmarked.

(b) Whenever the final date for filing a request for reconsideration or appeal prescribed in paragraph (a) of this section falls on a Saturday, Sunday, legal holiday, or other day on which the appropriate office is not open for the transaction of business during normal working hours, the time for filing shall be extended to the close of business on the next working day.

(c) A request for reconsideration or appeal may be accepted and acted upon even though it is not filed within the time prescribed in paragraphs (a) or (b) of this section if, in the judgment of the reviewing authority with whom such request is filed, the circumstances warrant such action. If the applicable reviewing authority declines acceptance of a late-filed request for reconsideration or appeal, such declination is not subject to further review.

§ 780.16 Form of request for reconsideration or appeal.

Each request for reconsideration or appeal shall be in writing and signed by the participant. Each request for reconsideration or appeal shall be supported by a written statement of facts, which may be submitted with or as a part of the request for reconsideration or appeal, or at any time prior to the scheduled hearing. The participant may request that a determination be made by the reviewing authority without a hearing on the basis of the written statement submitted and other information available to the reviewing authority. If the participant does not appear at the scheduled

hearing or otherwise make arrangements for a rescheduled hearing, the reviewing authority shall make its determination based on the facts available, including any additional material subsequently submitted by the participant.

§ 780.17 Determination.

(a) The reviewing authority, prior to making a determination, may request the producer or participant to produce additional evidence which it may deem relevant, or may develop additional evidence from other sources. Upon reconsideration or review and within program authorities, the reviewing authority may affirm, modify, or reverse any determination made by it initially or made by a lower reviewing authority, or may remand the matter to a lower reviewing authority for such further consideration as is deemed appropriate. The participant shall be notified in writing of the determination. The notification shall clearly set forth the basis for the determination. Any other person adversely affected by the determination shall be notified in writing of the determination.

(b) Except as provided in § 780.23, notwithstanding any other provision in this part, determinations:

(1) Made under a conservation program involving a finding or certification by a technician of the Soil Conservation Service or Forest Service, or determinations of a technical nature by any Federal agency, other than a determination made by ASCC, shall be binding on the reviewing authority;

(2) Which are solely due to general program provisions or statutory requirements which are applicable to all participants or producers are not appealable; and

(3) Which are solely the result of a mathematical calculation in accordance with a formula established under a statute or program regulation are not appealable.

(c) Program determinations issued by a State or county committee, or employees of such committees, made in good faith in the absence of misrepresentation, false statements, fraud, or wilful misconduct by the participant, unless otherwise appealed under these regulations or modified under § 780.23 within 90 days, shall be final and no action shall be taken to recover amounts found to have been disbursed thereon in error unless the producer had reason to believe that the determination was erroneous.

(d) Notwithstanding the provision of paragraph (c) of this section, representatives of ASCS and CCC may correct all errors in entering data on

program contracts, loan agreements and other program documents and the results of computations or calculations made pursuant to the contract or agreement.

§ 780.18 Reopening of hearing.

The reviewing authority may, upon its own motion for any reason it deems appropriate, or upon request of the participant when such request is accompanied by production of new and substantive information which could have a bearing on the prior determination, reopen any hearing unless the matter has been appealed to or considered by a higher reviewing authority.

§ 780.19 Procedure for appeals to the National Appeals Division.

(a) The Director: (1) Upon request, shall have access to all records, reports, audits, reviews, documents, papers, recommendations, or other material available that relate to programs and operations with respect to which an appeal has been taken;

(2) May request such information or assistance as may be deemed necessary from any Federal, State, or local governmental agency or unit thereof;

(3) May require the attendance of witnesses, the production of all information, documents, reports, answers, records, accounts, papers, and other data and documentary evidence necessary to the proper resolution of appeals;

(4) May, if appropriate, require the attendance of witnesses and production of documentary evidence by subpoena, which subpoena, in the case of contumacy or refusal to obey, shall be enforceable by order of any appropriate United States district court;

(5) May administer oaths and affirmations, whenever necessary in the process of hearing appeals;

(6) May delegate to hearing officers the authority to take actions provided in paragraphs (a)(1) through (5) of this section if deemed appropriate by the Director;

(7) Shall make all determinations with respect to appeals to NAD based on a copy of the record, certified and presented by the hearing officer to the Director; and

(8) May order further proceedings in order that the record presented for review may be complete or in order to hear new or additional evidence.

(b) In addition to the requirements set forth at section 780.9, additional requirements, as determined necessary, may be established by the Director.

§ 780.20 Participant request for exercise of subpoena powers.

A participant may request the Director to issue a subpoena as provided in section 780.19. The Director shall only issue a subpoena upon request if the Director determines that:

(a) The participant has established that production of documentary evidence is reasonably calculated to lead to information which would affect the final determination or is necessary to fully present the participant's case before NAD; or

(b) Upon a showing by the participant that either a representative of USDA or a private individual possesses information that is pertinent and necessary for disclosure of all relevant facts which could impact the final determination, and the information cannot be obtained except through testimony of the person, and the testimony cannot be obtained absent issuance of a subpoena.

(c) Testimony required pursuant to paragraph (b) of this section may, at the discretion of the Director, be presented at the hearing either in person or telephonically.

§§ 780.21-780.22 [Reserved]**§ 780.23 Delegation of authority.**

Nothing contained in the regulations of this part shall preclude the Secretary, Administrator of ASCS, or the Executive Vice President of CCC, or a designee, from determining at any time any question arising under the programs to which the regulations in this part apply, or from reversing or modifying in writing, with sufficient reason given therefor, any determination made by a country committee, State committee, the Director of NAD, or any other employee or representative of ASCS or CCC.

§ 780.24 OMB-control numbers assigned pursuant to the Paperwork Reduction Act.

The information collection requirements contained in these regulations (7 CFR part 780) have been approved by the Office of Management and Budget (OMB) under the provisions of 44 U.S.C. Chapter 35.

Signed this 20th day of November, 1991 at Washington, D.C.

Keith D. Bjerke,

Administrator, Agricultural Stabilization and Conservation Service, Executive Vice President, Commodity Credit Corporation.

[FR Doc. 91-28283 Filed 11-22-91; 8:45 am]

BILLING CODE 3410-05-M

SMALL BUSINESS ADMINISTRATION**13 CFR Part 101****Administration—Delegation of Authority for Financing Program**

AGENCY: Small Business Administration (SBA).

ACTION: Final rule.

SUMMARY: This rule increases the delegated authority of the branch managers of three SBA branch offices to approve SBA guaranteed loans. This change will expedite Agency action in processing loan applications.

EFFECTIVE DATE: This rule is effective November 25, 1991.

FOR FURTHER INFORMATION CONTACT:

Charles R. Hertzberg, Assistant Administrator for Financial Assistance, Small Business Administration, 409 Third Street, SW., Washington, DC 20416. Tel (202) 205-6490.

SUPPLEMENTARY INFORMATION: The SBA branch managers in Harrisburg and Wilkes Barre, Pa., and in Wilmington, Del. have successfully completed training courses offered by the Agency. This qualifies them to better analyze and process loan applications submitted by participating lenders for SBA guarantees. The Agency guaranty can range from 80% to 90% of the amount of a loan, so SBA wants to have qualified loan officers to process expeditiously and accurately the applications submitted. If branch managers have this capacity, loan applications for greater amounts need not be transmitted to a district office for processing. If greater loan amounts can be processed at the branch level, the loan applicant and the lender are both served with quicker and more accurate processing, and SBA is served by quality lending and better relations with its participating lenders.

At the present time, the managers of the three named branches have the authority to approve SBA guarantees for up to \$250,000. This amendment increases their authority to \$750,000, and SBA is undertaking this change in their delegation of authority in light of their training which qualifies them for increased responsibility.

Due to the fact that this final rule governs matters of agency organization, management and personnel and makes no substantive change to the current regulation, SBA is not required to determine if these changes constitute a major rule for purposes of Executive Order 2291, to determine if they have a significant economic impact on a substantial number of small entities pursuant to the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*), or to do a

Federalism assessment pursuant to Executive Order 12612. Finally, SBA certifies that these changes will not impose an annual recordkeeping or reporting requirement on 10 or more persons under the Paperwork Reduction Act (44 U.S.C. ch 35).

SBA is publishing this regulation governing agency organization, procedure and practice as a final rule without opportunity for public comment pursuant to 5 U.S.C. 553(b)(3)(A).

List of subjects in 13 CFR Part 101

Authority delegations (Government agencies), Administrative practice and procedure, Organization and functions (Government agencies).

PART 101—[AMENDED]

Accordingly, part 101 of title 13, chapter I of the Code of Federal Regulations, is hereby amended as follows:

1. The authority citation for part 101 continues to read as follows:

Authority: Secs. 4 and 5, Pub. L. 85-536, 72 Stat. 384 and 385 (15 U.S.C. 633 and 634, as amended); sec. 308, Pub. L. 85-699, 72 Stat. 694 (15 U.S.C. 687, as amended); sec. 5(b)(11), Pub. L. 93-386 (Aug. 23, 1974); and 5 U.S.C. 552.

§ 101.3-2 [Amended]

2. In § 101.3-2, part I, section A, item 1.b is amended by adding a new line (18) to read "Branch Manager, Harrisburg, Pa., Wilkes-Barre, Pa., Wilmington, Del.", and the approve and decline columns each state "\$750,000".

(Catalog of Federal Domestic Assistance 59.012 Small Business Loans (Regular Business Loans—7(a) Loans))

Dated: September 12, 1991.

Patricia Saiki,

Administrator.

[FR Doc. 91-28232 Filed 11-22-91; 8:45 am]

BILLING CODE 8025-01-M

DEPARTMENT OF TRANSPORTATION**Federal Aviation Administration****14 CFR Parts 21 and 25**

[Docket No. NM-52; Special Conditions No. 25-ANM-40]

Special Conditions: Modified Boeing Model 767-200 and -300 Series Airplanes; Installation of a Medical Oxygen System Utilizing Liquid Oxygen

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of disposition of comment on final special conditions.

SUMMARY: This notice provides public notification of the disposition of comment received on Special Conditions No. 25-ANM-40 (56 FR 13071, March 29, 1991) which were issued to E-Systems for design of Civil Reserve Air Fleet aeromedical evacuation ship set kits used to modify Boeing Model 767-200 and -300 series airplanes. These special conditions were issued by the Assistant Manager, Transport Airplane Directorate, Aircraft Certification Service, on March 19, 1991 and made effective on that date. The FAA determined that good cause existed for making those special conditions effective upon issuance (without previous notice); and invited interested persons to submit such written data, views, or arguments on those special conditions as they desired by May 13, 1991.

FOR FURTHER INFORMATION CONTACT: William Schroeder, FAA, Standardization Branch, ANM-113, Transport Airplane Directorate, Aircraft Certification Service, 1601 Lind Avenue, SW., Renton, Washington 98055-4056; telephone (206) 227-2148.

SUPPLEMENTARY INFORMATION:

Disposition of Comment

On June 26, 1991, the FAA received a comment from an organization representing airline pilots, expressing concern about having liquid oxygen on aircraft piloted by their members. In their understanding, commercial air carriers do not use liquid oxygen, and hence, have not established procedures and trained personnel to handle it. They stated that if the FAA approves these special conditions it is incumbent that it also ensure that adequate maintenance and operations procedures are developed and followed.

The FAA agrees with the commenter. The procedures for using therapeutic oxygen from a system that utilizes liquid oxygen for storage are the same as those for users of therapeutic oxygen from a system that utilizes high pressure oxygen for storage. The personnel administering or receiving the oxygen will be unable to detect a difference. Oxygen systems that utilize liquid oxygen for storage require special operations and maintenance procedures to assure safety. The special operations and maintenance instructions for this system are contained in documents which are included as part of the Supplemental Type Certificate (STC) approved modification kit. These

documents are included with each kit installation along with the Flight Manual Supplement to assure appropriate operations and maintenance procedures are provided to operators.

No change to Special Conditions No. 25-ANM-40 has been made as a result of this comment and response.

Issued in Renton, Washington, on November 14, 1991.

Leroy A. Keith,

Manager, Transport Airplane Directorate, Aircraft Certification Service, ANM-100.

[FR Doc. 91-28306 Filed 11-22-91; 8:45 am]

BILLING CODE 4910-13-M

14 CFR Part 39

[Docket No. 91-NM-219-AD; Amdt. 39-8102; AD 91-25-01]

Airworthiness Directives; Israel Aircraft Industries (IAI), Ltd., Model 1125 Series Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This amendment adopts a new airworthiness directive (AD), applicable to all Israel Aircraft Industries (IAI), Ltd., Model 1125 series airplanes, which requires revisions to the FAA-approved Airplane Flight Manual (AFM) to include an operational check of the horizontal trim system, and to limit the use of the emergency trim system to only those conditions involving failure of the elevator control or failure of the horizontal stabilizer trim. This amendment is prompted by an incident in which the emergency trim system was deliberately activated under normal flying conditions. This condition, if not corrected, could result in uncontrolled pitch trim movement.

EFFECTIVE DATE: December 10, 1991.

ADDRESSES: The applicable service information may be obtained from Astra Jet Corporation, Technical Publications, 77 McCullough Drive, suite 11, New Castle, Delaware 19720. This information may be examined at the FAA, Northwest Mountain Region, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, Washington.

FOR FURTHER INFORMATION CONTACT: Mr. Mark Quam, Standardization Branch, ANM-113; telephone (206) 227-2145. Mailing address: FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, Washington 98055-4056.

SUPPLEMENTARY INFORMATION: The Civil Aviation Administration of Israel

(CAAI), in accordance with existing provisions of a bilateral airworthiness agreement, has notified the FAA of an unsafe condition which may exist on Israel Aircraft Industries (IAI), Ltd., Model 1125 Astra series airplanes. An incident occurred in which the pilot used the emergency trim system, as opposed to the normal trim system, during normal operations. Further investigation revealed that pilots apparently have found that the higher speeds of the emergency trim system provide faster trim adjustments when the pilot elects to change the configuration on an airplane. In the subject incident, a contactor stuck, which caused the trim to continue to drive (keeping the plane in a full nose-up attitude) until the circuit breaker popped. This condition, if not corrected, could result in uncontrolled pitch trim movement.

IAI, Ltd., has issued Astra Airplane Flight Manual Temporary Revision No. 3, dated June 9, 1991, which describes an operational check of the horizontal trim system, and limits the use of the emergency trim system to only those conditions involving failure of the elevator control or failure of the horizontal stabilizer trim. The CAAI has classified this document as mandatory and has issued Israeli Airworthiness Directive 91-03.

This airplane model is manufactured in Israel and type certificated in the United States under the provisions of § 21.29 of the Federal Aviation Regulations and the applicable bilateral airworthiness agreement.

Since this condition is likely to exist or develop on other airplanes of the same type design registered in the United States, this AD requires revisions to the FAA-approved Airplane Flight Manual (AFM) to include an operational check of the horizontal trim system, and to limit the use of the emergency trim system to only those conditions involving failure of the elevator control or failure of the horizontal stabilizer trim.

Since a situation exists that requires immediate adoption of this regulation, it is found that notice and public procedure hereon are impracticable, and good cause exists for making this amendment effective in less than 30 days.

The regulations adopted herein will not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance

with Executive Order 12612, it is determined that this final rule does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

The FAA has determined that this regulation is an emergency regulation and that it is not considered to be major under Executive Order 12291. It is impracticable for the agency to follow the procedures of Executive Order 12291 with respect to this rule since the rule must be issued immediately to correct an unsafe condition in aircraft. It has been determined further that this action involves an emergency regulation under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979). If it is determined that this emergency regulation otherwise would be significant under DOT Regulatory Policies and Procedures, a final regulatory evaluation will be prepared and placed in the Rules Docket (otherwise, an evaluation is not required). A copy of it, if filed, may be obtained from the Rules Docket.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Safety.

Adoption of the Amendment

Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration amends 14 CFR part 39 of the Federal Aviation Regulations as follows:

PART 39—[AMENDED]

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 1354(a), 1421 and 1423; 49 U.S.C. 106(g); and 14 CFR 11.89.

§ 39.13 [Amended]

2. Section 39.13 is amended by adding the following new airworthiness directive:

91-25-01. **Israel Aircraft Industries (IAI), Ltd.:** Amendment 39-8102. Docket No. 91-NM-219-AD.

Applicability: All Model 1125 series airplanes, certificated in any category.

Compliance: Required as indicated, unless previously accomplished.

To prevent uncontrolled pitch trim movement, accomplish the following:

(a) Within 3 days after the effective date of this AD, revise the Limitations Section of the FAA approved Airplane Flight Manual (AFM) to include the following. This may be done by inserting a copy of this AD in the AFM.

"Before Taxiing

Horizontal stabilizer trim—Check Overrd & Emerg; Emerg Arm pushbutton—Disengage, Check Normal (buzzer).

Note: When checking override system,

observe trim indicator; electrical limit switches are inoperative.

Caution

Do not use emergency trim in place of normal or override trim systems. Use of emergency trim is limited to elevator control failure (Section II, page II-28) and horizontal stabilizer trim failure (Section III, page III-9)."

Inserting Astra (Model 1125) AFM Temporary Revision No. 3, dated June 9, 1991, in the Limitations section of the AFM, or inserting an AFM revision containing this information, is considered an acceptable alternative method of compliance with this paragraph.

(b) Within 3 days after the effective date of this AD, revise the Normal Procedures Section of the FAA-approved AFM to include the following. This may be done by inserting a copy of this AD in the AFM.

"Before Taxiing

Horizontal stabilizer trim—Check Overrd & Emerg; Emerg Arm pushbutton—Disengage, Check Normal (buzzer).

Note: When checking override system, observe trim indicator; electrical limit switches are inoperative.

Caution

Do not use emergency trim in place of normal or override trim systems. Use of emergency trim is limited to elevator control failure (Section II, page II-28) and horizontal stabilizer trim failure (Section III, page III-9)."

Inserting Astra (Model 1125) AFM Temporary Revision No. 3, dated June 9, 1991, in the Procedures Section of the AFM, or inserting an AFM revision containing this information, is considered an acceptable alternative method of compliance with this paragraph.

(c) An alternative method of compliance or adjustment of the compliance time, which provides an acceptable level of safety, may be used when approved by the Manager, Standardization Branch, ANM-113, FAA, Transport Airplane Directorate.

Note: The request should be forwarded through an FAA Principal Operations Inspector, who may concur or comment and then send it to the Manager, Standardization Branch, ANM-113.

(d) Special flight permits may be issued in accordance with FAR 21.197 and 21.199 to operate airplanes to a base in order to comply with the requirements of this AD.

(e) This amendment (39-8102), AD 91-25-01, becomes effective December 10, 1991.

Issued in Renton, Washington, on November 14, 1991.

Leroy A. Keith,

Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 91-28304 Filed 11-22-91; 8:45 am]

BILLING CODE 4910-13-M

DEPARTMENT OF THE TREASURY

Bureau of Alcohol, Tobacco and Firearms

27 CFR Part 9

[T.D. ATF-317; RE: Notice No. 714]

RIN 1512-AA07

The Grand Valley Viticultural Area (89F197P)

AGENCY: Bureau of Alcohol, Tobacco and Firearms, Department of the Treasury.

ACTION: Final rule, Treasury decision.

SUMMARY: This final rule establishes a viticultural area known as Grand Valley which is located totally within Mesa County, Colorado. The petition was submitted by Mr. Jim Seewald of Vintage Colorado Cellars Winery. The establishment of viticultural areas and the subsequent use of viticultural area names in wine labeling and advertising allows wineries to designate the specific areas where the grapes used to make their wines were grown and enables consumers to better identify wines they purchase.

EFFECTIVE DATE: December 26, 1991.

FOR FURTHER INFORMATION CONTACT: Robert White, Wine and Beer Branch, Bureau of Alcohol, Tobacco and Firearms, 650 Massachusetts Ave., NW., Washington, DC 20226 (202-927-8230).

SUPPLEMENTARY INFORMATION:

Background

On August 23, 1978, ATF published Treasury Decision ATF-53 (43 FR 37672, 54624) revising regulations in 27 CFR part 4. These regulations allow the establishment of definitive viticultural areas. The regulations allow the name of an approved viticultural area to be used as an appellation of origin on wine labels and in wine advertisements. On October 2, 1979, ATF published Treasury Decision ATF-60 (44 FR 56692) which added a new part 9 to 27 CFR, for the listing of approved American viticultural areas. Section 4.25a(e)(1), title 27 CFR, defines an American viticultural area as a delimited grape-growing region distinguishable by geographical features, the boundaries of which have been delineated in subpart C of part 9. Section 4.25a(e)(2) outlines the procedure for proposing an American viticultural area. Any interested person may petition ATF to establish a grape-growing region as a viticultural area.

Petition

ATF received a petition from Mr. James E. Seewald, President of Vintage Colorado Cellars Corporation, proposing an area in Mesa County, Colorado, as a viticultural area to be known as "Grand Valley." The viticultural area is located in the Grand Junction area, between Palisade and Fruita, in the western part of the State.

There are two wineries and approximately 16 vineyards located within the area, with a total of about 80 to 90 acres planted to wine grapes. The approximate size of the Grand Valley viticultural area is in the neighborhood of 50 square miles. In response to Mr. Seewald's petition, ATF published a notice of proposed rulemaking, Notice No. 714, in the *Federal Register* on March 20, 1991 (56 FR 11712), proposing the establishment of the Grand Valley viticultural area.

Comments

ATF received four comments during the 45-day comment period which ended on May 6, 1991. The first comment, from a local grape grower, fully supported the petition. The second comment came from Grande River Vineyards, a bonded winery located within the viticultural area. Grande River Vineyards stated that while they supported the viticultural area, they were concerned about a potential conflict with the provisions of 27 CFR 4.39(i), which restricts the use of brand names of viticultural significance. A brand name has viticultural significance when, among other things, it is the name of an approved viticultural area, or when it is found to have viticultural significance by the Director. Grande River Vineyards was concerned that ATF would find the name of their winery to have viticultural significance based on its similarity to the name of the Grand Valley viticultural area.

ATF does not believe that the names "Grande River Vineyards" and "Grand Valley" are similar enough to consider "Grande River Vineyards" as a brand name of viticultural significance. Thus, the approval of the Grand Valley viticultural area will in no way adversely affect the ability of Grande River Vineyards to use the name of their winery as a trade name or a brand name on wine labels. The third comment came from Mr. Douglas R. Phillips, on behalf of the Colorado Wine Industry Development Board. Mr. Phillips requested that the viticultural area be expanded to include a contiguous orchard development located in an area known as Rapid Creek. He stated that Rapid Creek, which is immediately

adjacent to the northeastern boundary of the Grand Valley viticultural area, was one of the oldest orchard areas in the State. He stated that this area is located at the mouth of the canyon where the Colorado River enters the Grand Valley, and has historically been referred to as a portion of the Grand Valley. The comment also stated that at least one orchard owner in the area is planning to grow grapes in the future. Mr. Phillips subsequently sent another letter, which contained a description of the boundaries of the proposed expansion. The fourth comment came from the petitioner, in response to Mr. Phillips' comment. The petitioner stated that the Rapid Creek area is not known as part of the Grand Valley, and pointed to the fact that the Rapid Creek area lies outside of the "Grand Valley Unit" of the salinity control area established by the Agricultural Stabilization and Conservation Service of the United States Department of Agriculture. The petitioner stated that the geographical features of the area known as Rapid Creek were different from those of the Grand Valley, stating that the U.S.G.S. map titled "Palisade Quadrangle" clearly showed that the Rapid Creek area was a very steep, hilly and rocky area. The petitioner also stated that the area known as Rapid Creek differed from the Grand Valley area in both temperature and wind drainage.

Pursuant to 27 CFR 4.25a(e)(2), any person may petition for the establishment of an American viticultural area. The petition must include evidence that the name of the viticultural area is locally or nationally known as referring to the area specified in the petition; historical or current evidence that the boundaries of the viticultural area are as specified in the petition; evidence relating to the geographical features (climate, soil, elevation, physical features, etc.) which distinguish the viticultural features of the proposed area from surrounding areas; the specific boundaries of the viticultural area, based on features which can be found on U.S.G.S. maps of the largest applicable scale; and copies of the appropriate maps, with the boundaries prominently marked.

Mr. Phillips submitted a description of the boundaries of the proposed extension, but he failed to submit evidence that the area was locally or nationally known as part of the Grand Valley. Nor did Mr. Phillips submit historical or current evidence that the boundaries of the Grand Valley extended to include the Rapid Creek area, or evidence that the distinguishing geographical features of the Grand

Valley were shared by the Rapid Creek area. ATF responded to Mr. Phillips' comment by affording him a period of 30 days to submit evidence, in accordance with § 4.25a(e)(2), which would support the request to extend the Grand Valley area into the Rapid Creek area. At the expiration of this period, ATF contacted Mr. Phillips again, and he stated that he had not been able to obtain such evidence. Due to the lack of any evidence which would support the extension of the Grand Valley viticultural area into the Rapid Creek area, ATF has decided to adopt the boundaries of the Grand Valley viticultural area as proposed in Notice No. 714 without change.

Viticultural Area Name

The name "Grand Valley" has been associated with the area since at least the mid-nineteenth century. Historical and current usage of the name is supported by the following:

(1) The Geological Survey Professional Paper 451, titled "Geology and Artesian Water Supply, Grand Junction Area, Colorado," states "The present Colorado River above Grand Junction was known as the Grand River at least as early as 1842 * * * The city of Grand Junction was so named because of its position at the junction of the Gunnison and Grand Rivers. The Green and Grand Rivers united in eastern Utah to become the Colorado River * * * The Grand River was renamed Colorado River by act of the Colorado State Legislature, approved March 24, 1921, and by act of Congress approved July 25, 1921; but, in addition to Grand Junction, the name Grand still remains in the Grand Valley between Palisade and Mack; in Grand Mesa, which stands more than a mile above the Grand and Gunnison Valleys * * * and in Grand County, Colorado * * *"

(2) "The Valley of the Grand—The Place for You," issued by the Chamber of Commerce Grand Junction, Colorado Historic Catalog, circa 1907, details "Specimens of Grand Valley Grapes."

(3) The Geographic Names Information System (G.N.I.S.) State of Colorado, Alphabetical Finding List, dated February 25, 1981, lists the following entry: Name—Grand Valley, Feature/Class—ppt, State/County—08045, Coordinate—392707N1080308W.

(4) The Grand Junction Area Chamber of Commerce map/brochure, dated 1988, describes, under the section titled "History of Grand Junction," a brief history of the area beginning with "The isolated barren Grand Valley was traveled by a mere handful of hardy pioneers prior to 1879."

(5) Soil Survey of the Grand Junction Area, Colorado Series 1940, No. 19, issued November 1955, frequently refers to the Grand Valley, particularly on the fold out pages 6 and 7.

Historical/Current Evidence of Boundaries

According to the Soil Survey of the Grand Junction Area, Colorado, the viticultural area is in the Grand Valley of Colorado near the western edge of Mesa County. The area is located in the Canyon Lands section of the Colorado Plateau physiographic province. It occupies part of the floor of a deep pocket, or valley, known as the Grand Valley of Colorado. This valley, carved in the Mancos Shale formation by the Colorado and Gunnison Rivers and their tributaries, is surrounded for the most part by steep mountainous terrain. Deep canyons flank the valley to the southwest; a sharp escarpment known as the Book Cliffs rises above it to the north and northeast; foot slopes of the Grand Mesa lie to the east; and rough broken and steep, hilly land that borders high terraces or mesas lies to the south. According to the petitioner, the Grand Valley is usually thought of as the area between the towns of Palisade and Mack. However, the western boundary of the Grand Valley viticultural area stops at the town of Fruita, rather than extending further west to Mack, because of geographical and climatical features which distinguish the viticultural area from the area west of Fruita. The first is that there is a difference in the quality of the soil as one moves toward the western end of the Grand Valley. Much of the soil in this area will not support grape vines due to excessive salts. Also, there is a lack of supply of water for irrigation of the soil west of Fruita.

The second reason is that daily weather reports throughout the winter months always show the higher, more favorable, temperatures to be in the eastern (Palisade) end, and moving progressively westward, the temperatures (at exactly the same time of day or night) decrease with the coldest areas being reported in Mack and Loma on the western end of the valley. Since it does not appear that the area west of Fruita would support grape vines, we have ended the western boundary of the Grand Valley viticultural area at Fruita rather than extending it to Mack.

The "Grand Valley" viticultural area includes within its boundaries three areas which are locally known by the names of Orchard Mesa, the Redlands, and the Vinelands. Orchard Mesa is a tract of almost flat terrace land south of the Colorado River and to the southeast

of Grand Junction. The Redlands is a rolling and somewhat hilly area south of the Colorado River and between the mouth of the Gunnison River and Fruita. The Vinelands is a tract of land located southeast of the town of Palisade.

Geographical Features

Elevations in the "Grand Valley" viticultural area rise from 4500 feet at the western end near Fruita to 4573 feet at Grand Junction, and 4729 feet at the eastern end of the Valley near Palisade. Deep canyons flank the Valley to the southwest. A sharp escarpment (Book Cliffs) rises to 7000 feet above the Valley to the north and northeast. The Grand Mesa stands more than a mile above the eastern edge of the Valley, and steep, hilly land borders the high terraces and mesas to the south.

The climate of the "Grand Valley" viticultural area is similar to that of most of the intermountain areas west of the Continental Divide in its aridity, wide range of daily temperatures, high percentage of bright sunny days, and high evaporation rate. Where the climate differs, the differences apparently are caused by protective mountain barriers.

In the extreme eastern part of the area, the Colorado River enters the Grand Valley through a steep narrow canyon that tends to stabilize air currents in the Valley. During the day, the air tends to move up the slopes that confine the Valley at its eastern end. Then, at night, the air moves down again. This air movement, spoken of as air drainage, affords a more limited daily range in temperature and less danger from frost, particularly at the eastern end of the Grand Valley where the majority of the vinifera plantings are located. Hence, the eastern section of the Valley, to a distance of about 3 or 4 miles west of Palisade, has a climate particularly suitable for orchard fruits and grapes. Summer temperatures rise to a maximum of about 105 degrees Fahrenheit. Several days in summer may have temperatures above 100 degrees. The nights are cool, however. Also, the winters are mild. Temperatures are usually above zero, though an absolute minimum of minus 21 degrees has been recorded. The average humidity is low, so zero weather does not seem so cold nor the summers so hot as in States where the humidity is higher.

The average date of the last killing frost in spring is April 14, and the first in fall is October 21. The average frost-free, or growing season is 190 days. Occasionally, late spring or early fall frosts do some damage to fruits and vegetables on the bottom lands and recent flood plains. On the mesas or

higher terraces, frost damage is slight. Frost is especially rare in the climatically protected areas around Palisade and along the bluffs bordering the Redlands. High winds are unusual, and cyclones are unknown. Light thundershowers are common during summer. Hail damage is localized and usually slight. Summer showers are frequently more detrimental than beneficial, especially those that come during the harvesting season.

The average annual precipitation at Grand Junction is 9.06 inches per year. This precipitation is well distributed throughout the year but is not sufficient to permit successful dry farming. The soils support only a scant growth of native grasses and shrubs if they are not irrigated. The average snowfall is 22.0 inches. The snow usually melts within a few days after it falls. The ground is free of snow most of the winter.

The "Grand Valley" viticultural area is distinguishable from surrounding areas by elevation and by soil differences. In addition to the cliffs and mesas to the north and east of the valley, the surrounding areas to the northwest, west and south contain soils which are usually more alkaline than the soils within the Grand Valley viticultural area. For the most part, these areas are not capable of being irrigated and are suitable only for livestock grazing. They are rocky, often steeply sloped, and the soils are classified from fair to poor, to non-existent. Large areas to the south, along the Gunnison River and Colorado Highway 50, show extensive evidence of excessive salts and alkalinity.

The nearest commercial vineyards outside the viticultural area are located in excess of 50 miles from the Grand Valley with mountains, mesas, valleys, canyons, and vast areas of salt, sagebrush and alkali separating the two. Grapes within the "Grand Valley" viticultural area are adapted to the medium textured to sandy Genola, Hinman, Mayfield, Mesa, Ravola, and Thoroughfare soils, especially where these soils are in areas where peaches are grown, since grapes and peaches tend to do well in the same type of environment. In contrast, soils to the west of the viticultural area are predominantly Billings, Chipeta, Fruita, Mack and Persayo-Chipeta which, for the most part, are not suitable for grape growing.

Boundary

The boundary of the Grand Valley viticultural area may be found on six United States Geological Survey maps

with a scale of 1:24,000. The boundary is described in § 9.137.

Miscellaneous

ATF does not wish to give the impression by approving the Grand Valley viticultural area that it is approving or endorsing the quality of the wine from this area. ATF is approving this area as being distinct from surrounding areas, not better than other areas. By approving this area, ATF will allow wine producers to claim a distinction on labels and advertisements as to origin of the grapes. Any commercial advantage gained can only come from consumer acceptance of Grand Valley wines.

Executive Order 12291

It has been determined that this document is not a major regulation as defined in E.O. 12291 and a regulatory impact analysis is not required because it will not have an annual effect on the economy of \$100 million or more; it will not result in a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; and it will not have significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

Regulatory Flexibility Act

It is hereby certified that this regulation will not have a significant economic impact on a substantial number of small entities. Accordingly, a regulatory flexibility analysis is not required because the final rule is not expected (1) to have secondary, or incidental effects on a substantial number of small entities; or (2) to impose, or otherwise cause a significant increase in the reporting, recordkeeping, or other compliance burdens on a substantial number of small entities.

Paperwork Reduction Act

The provisions of the Paperwork Reduction Act of 1980, Public Law 96-511, 44 U.S.C. chapter 35, and its implementing regulations, 5 CFR part 1320, do not apply to this final rule because no requirement to collect information is imposed.

Drafting Information

The principal author of this document is Robert L. White, Wine and Beer Branch, Bureau of Alcohol, Tobacco and Firearms.

List of Subjects in 27 CFR Part 9

Administrative practice and procedure, Consumer protection, Viticultural areas, Wine.

Issuance

Title 27, Code of Federal Regulations, Part 9, American Viticultural Areas is amended as follows:

PART 9—AMERICAN VITICULTURAL AREAS

Par. 1. The authority citation for part 9 continues to read as follows:

Authority: 27 U.S.C. 205.

Par. 2. The Table of sections in subpart C is amended to add the title of § 9.137 to read as follows:

Subpart C—Approved American Viticultural Areas

Sec.

* * * * *

§ 9.137 Grand Valley.

Par. 3. Subpart C is amended by adding § 9.137 to read as follows:

Subpart C—Approved American Viticultural Areas

* * * * *

§ 9.137 Grand Valley.

(a) *Name.* The name of the viticultural area described in this section is "Grand Valley."

(b) *Approved maps.* The appropriate maps for determining the boundary of the Grand Valley viticultural area are six U.S.G.S. (7.5 minute series) topographical maps of the 1:24,000 scale:

- (1) "Palisade Quadrangle, Colorado," edition of 1962.
- (2) "Clifton Quadrangle, Colorado," edition of 1962, photorevised 1973.
- (3) "Grand Junction Quadrangle, Colorado," edition of 1962, photorevised 1973.
- (4) "Colorado National Monument Quadrangle, Colorado," edition of 1962, photorevised 1973.
- (5) "Fruita Quadrangle, Colorado," edition of 1962, photorevised 1973.
- (6) "Corcoran Point Quadrangle, Colorado," edition of 1962.

(c) *Boundary.* The Grand Valley viticultural area is located entirely within Mesa County, Colorado, in the western part of the State. The boundary is as follows:

(1) The beginning point is located on the Palisade quadrangle map at a point northeast of the city of Palisade where Interstate 70 crosses the Colorado River and intersects with U.S. Highways 6 and 24, adjacent to and immediately west of the Orchard Mesa Canal Aqueduct;

(2) From the beginning point, the boundary proceeds due east to the adjacent Orchard Mesa Canal Aqueduct and then in a southerly direction along the Orchard Mesa Canal Aqueduct to an unnamed creek in the western part of section 11, Township 11 South, Range 98 West (T. 11 S., R. 98 W.);

(3) Thence in a southeasterly direction along the unnamed creek to its intersection with the 5000-foot contour line in the northeast corner of section 1, T. 1 S., R. 2 E.;

(4) Thence in a northwesterly and then a southerly direction along the 5000-foot contour line to its intersection with Watson Creek in section 12, T. 1 S., R. 2 E.;

(5) Thence in a southeasterly direction along Watson Creek to its intersection with the electrical power lines in the southern part of section 12, T. 1 S., R. 2 E.;

(6) Thence in a southwesterly direction along the electrical power lines along the northern slope of Horse Mountain to that point where the power lines intersect with the Jeep Trail in the central part of section 15, T. 1 S., R. 2 E.;

(7) Thence in a northwesterly direction along the Jeep Trail to its intersection with Orchard Mesa Canal No. 2 on the western border of section 10, T. 1 S., R. 2 E.;

(8) Thence in a generally southwesterly direction along Orchard Mesa Canal No. 2 through the Clifton quadrangle map to the Canal's junction with the Gunnison River on the Grand Junction quadrangle map (western part of section 31, T. 1 S., R. 1 E.);

(9) Thence in a generally northwesterly direction along the Gunnison River to its junction with the Colorado River in section 22, T. 1 S., R. 1 W.;

(10) Thence continuing in a northwesterly direction along the Colorado River to the bridge where County Road 340 crosses the river (Section 15, T. 1 S., R. 1 W.);

(11) Thence in a southwesterly direction along County Road 340 approximately .2 mile to its intersection with a secondary highway, hard surface road, known locally as Monument Road;

(12) Thence in a southwesterly direction along Monument Road to the boundary of the Colorado National Monument, located on the Colorado National Monument quadrangle map (section 30, T. 1 S., R. 1 W.);

(13) Thence in a generally northwesterly direction along the boundary of the Colorado National Monument to its intersection with County Road 340 (known locally as

Broadway) on the northern border of section 32, T. 1 N., R. 2 W.;

(14) Thence in a generally northerly direction along County Road 340 to the city of Fruita where County Road 340 (known locally as Cherry Street) intersects K Road on the Fruita quadrangle map;

(15) Thence due east on K Road to the northeast corner of section 17, T. 1 N., R. 1 W., on the Corcoran Point quadrangle map, then extending in the same direction in a straight line along the northern boundary of section 16, T. 1 N., R. 1 W. to the intersection with the Government Highline Canal;

(16) Thence in a southeasterly direction along the Government Highline Canal to its intersection with U.S. Interstate 70 on the Grand Junction quadrangle map;

(17) Thence in an easterly direction along U.S. Interstate 70 through the Clifton quadrangle map to where Interstate 70 crosses the Colorado River and intersects with U.S. Highways 6 and 24 on the Palisade quadrangle map, the point of beginning.

Signed: October 11, 1991.

Stephen E. Higgins,
Director.

Approved: November 4, 1991.

John P. Simpson,
Deputy Assistant Secretary (Regulatory,
Trade and Tariff Enforcement).
[FR Doc. 91-28168 Filed 11-22-91; 8:45 am]
BILLING CODE 4810-31-M

DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Parts 286i and 293

Defense Mapping Agency (DMA) Freedom of Information Act Program; Correction

AGENCY: Office of the Secretary, DoD.
ACTION: Final rule correction.

SUMMARY: This document corrects an administrative error that appeared in the *Federal Register* on November 18, 1991. The publication redesignated 286i as 295. The correct redesignation is "286i" as "293".

EFFECTIVE DATE: July 10, 1991.

FOR FURTHER INFORMATION CONTACT: L.M. Bynum, Correspondence and Directives Directorate, Washington Headquarters Services, Pentagon, Washington, DC 20301-1155, telephone 703-697-4111.

In the *Federal Register* issue of Monday, November 18, 1991, pages 58179 and 58180, "295" is corrected to read "293" each time it appears.

Dated: November 19, 1991.

L.M. Bynum,

Alternate OSD Federal Register Liaison
Officer.

[FR Doc. 91-28181 Filed 11-22-91; 8:45 am]

BILLING CODE 3810-01-M

Department of the Navy

32 CFR Part 701

[Secretary of the Navy Instruction 5211.5C]

Personal Privacy and Rights of Individuals Regarding Records Pertaining to Themselves

AGENCY: Department of the Navy, DOD.

ACTION: Final rule.

SUMMARY: The Department of the Navy is removing an exemption rule subject to the Privacy Act of 1974 (5 U.S.C. 552a). This exemption rule removes the system of records identified as N01610-1, "Navy Personnel Evaluation System" which is also removed in a Navy Notice document published elsewhere in this *Federal Register*. The Navy is also changing "Naval Military Personnel Command" to "Bureau of Naval Personnel" to reflect the activity's name change.

EFFECTIVE DATE: November 25, 1991.

FOR FURTHER INFORMATION CONTACT: Mrs. Gwendolyn Aitken, Head, PA/FOIA Branch, Office of the Chief of Naval Operations (OP-09B30), Department of the Navy, The Pentagon, Washington, DC 20350-2000. Telephone (703) 614-2004.

SUPPLEMENTARY INFORMATION:

List of Subjects in 32 CFR Part 701

Privacy.

For the reasons set forth in the preamble, 32 CFR 701.119 is amended as follows:

1. The authority citation for 32 CFR part 701, subpart G is revised to read as follows:

Authority: Pub. L. 93-579, 88 Stat 1896 (5 U.S.C. 552a).

2. Section 701.119 is amended by revising the section heading; the heading of paragraph (b); and removing and reserving paragraph (b)(2) as follows:

§ 701.119 Exempt Navy record systems.

* * * * *

(b) Bureau of Naval Personnel—

* * * * *

(2) [Reserved]

* * * * *

Dated: November 19, 1991.

L.M. Bynum,

Alternate OSD Federal Register Liaison
Officer, Department of Defense.

[FR Doc. 91-28182 Filed 11-22-91; 8:45 am]

BILLING CODE 3810-01-M

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 1

RIN 2900-AF56

Release of Department of Veterans Affairs (VA) List of Names and Addresses

AGENCY: Department of Veterans
Affairs.

ACTION: Final rule.

SUMMARY: The Department of Veterans Affairs is amending the regulation governing the release of lists of VA beneficiaries under the authority of 38 U.S.C. 3301 to delegate authority to the General Counsel to make final Departmental decisions on appeals. The Office of the General Counsel has been extensively involved in the preparation of final Departmental decisions on appeals under this authority since the decisions require legal analysis. This new delegation of authority should allow the Department to be more responsive to the public.

EFFECTIVE DATE: November 25, 1991.

FOR FURTHER INFORMATION CONTACT: Marjorie M. Leandri, Chief, Records and Reports Management Division (723), Records Management Service, Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 233-2454.

SUPPLEMENTARY INFORMATION: VA finds that advance publication for notice and public comment is not required. The regulatory amendment here involved is consistent with the Secretary's lawful ability to delegate his authority in providing final Departmental decisions on appeals on information law issues. This amendment reflects the general change in Department policy regarding who may responsibly issue such final decisions, and neither imposes new obligations nor has a substantial impact on those individuals dealing with the Department. Such amendment affects only existing Departmental procedures and practices which is not substantive in its effect. Thus, in accordance with the provisions of 38 CFR 1.12, advance publication in the *Federal Register* is not necessary. Accordingly, the amendment

in the foregoing regulation is now published as final.

This final regulatory amendment does not meet the criteria for a major rule as that term is defined by Executive Order 12291, Federal Regulation. This regulatory amendment will not have a \$100 million annual effect on the economy, will not cause a major increase in costs or prices and will not have any other significant adverse effects on the economy.

The Secretary hereby certifies that this regulation will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601-612. Pursuant to 5 U.S.C. 605(b), this regulation is therefore exempt from the regulatory analysis requirements of 5 U.S.C. 603 and 604. The reason for this certification is that the involved regulation applies only to delegations of authority specifying who will make final Departmental decisions on appeals under information laws, and imposes no regulatory burden on small entities.

There is no applicable Catalog of Federal Domestic Assistance number involved.

List of Subjects in 38 CFR Part 1

Administrative practice and procedure, Freedom of information, Government employees, Government property, Investigations, Privacy.

Approved: November 12, 1991.

Edward J. Derwinski,
Secretary of Veterans Affairs.

For the reasons set out in the preamble, 38 CFR part 1 is amended as set forth below:

PART 1—[AMENDED]

1. The authority citation for part 1, §§ 1.500 to 1.527 continues to read as follows:

Authority: Sections 1.500 to 1.527 issued under 72 Stat. 1114, 1236, as amended; 38 U.S.C. 210, 3301.

§ 1.519 [Amended]

2. In § 1.519, paragraph (e), remove the word "Secretary" and add, in its place, the words "General Counsel".

[FR Doc. 91-28210 Filed 11-22-91; 8:45 am]

BILLING CODE 8320-01-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

42 CFR Part 110

RIN 0905-AC83

Vaccine Information Materials

AGENCY: Centers for Disease Control, Public Health Service, HHS.

ACTION: Final rule; corrections.

SUMMARY: The Public Health Service is making minor corrections to the final rule on Vaccine Information Materials (42 CFR part 110) published Tuesday, October 15, 1991 (56 FR 51798). Other corrections appear in the Corrections Section of this issue.

FOR FURTHER INFORMATION CONTACT: Walter A. Orenstein, M.D., Director, Division of Immunization, Mailstop E-05, National Center for Prevention Services, Centers for Disease Control, Atlanta, Georgia 30333.

SUPPLEMENTARY INFORMATION: On October 15, 1991, the Public Health Service published the final rule on Vaccine Information Materials (42 CFR part 110; 56 FR 51798). Appendix A to subpart A includes information materials for Diphtheria, Tetanus, and Pertussis; Measles, Mumps, and Rubella; and Polio. This notice changes the dates that appear in those materials to the date of publication and corrects an error. Other changes are made in another notice appearing in the Corrections Section of this issue.

* * * * *

Dated: November 18, 1991.

Neil J. Stillman,

Deputy Assistant Secretary for Information Resources Management.

The following corrections are made to appendix A to Subpart A, Vaccine Information Materials, Final Rule, 42 CFR part 110:

Appendix A to Subpart A [Corrected]

1. On page 51811, third column, line 37, change "DTP 00/00/91" to "DTP 10/15/91".

2. On page 51812, directly below the form, change "DTP 00/00/90" to "DTP 10/15/91".

3. On page 51815, third column, line 18, change "MMR 00/00/91" to "MMR 10/15/91".

4. On page 51815, directly below the form, change "MMR 00/00/90" to "MMR 10/15/91".

5. On page 51815, first column, line 16,

change "The benefit of polio vaccine is" to "The benefits of polio vaccine are".

6. On page 51818, third column, line 11, change "Polio 00/00/91" to "Polio 10/15/91".

7. On page 51818, directly below the form, change "Polio 00/00/90" to "Polio 10/15/91".

[FR Doc. 91-28169 Filed 11-22-91; 8:45 am]

BILLING CODE 4160-18-M

Health Care Financing Administration

42 CFR Parts 412 and 413

[BPD-711-CN]

RIN 0938-AE90

Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1992 Rates; Correction

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule; correction.

SUMMARY: In the August 30, 1991, issue of the Federal Register (FR Doc. 91-20778), (56 FR 43196), we revised the Medicare inpatient hospital prospective payment system and the amounts and factors necessary to determine prospective payment rates for Medicare inpatient hospital services. These changes are applicable to discharges occurring on or after October 1, 1991. This notice corrects errors made in that document.

EFFECTIVE DATE: October 1, 1991.

FOR FURTHER INFORMATION CONTACT: Barbara Wynn, (301) 966-4529.

SUPPLEMENTARY INFORMATION: We are making the following corrections to the August 30, 1991 final rule (56 FR 43196):

1. On page 43206, in the first column, under section 4, Chemotherapy (DRG 410), in line 16 of the second paragraph, the last diagnosis code is changed from 208.1 to 208.01.

2. On page 43223, in the third column, under the first response paragraph, on line 9 and beginning on line 14, the date of December 19, 1991 is changed to December 18, 1991.

3. On page 43226, in the second column, in Step 5: Computation of Capital DSH and IME Adjustments for Day Outliers, the equation is changed as follows:

From: Capital Outlier
Payment × (Capital IME Adjustment Factor + Capital DSH Adjustment Factor) = DSH Outlier Adjustment
To: Capital Outlier Payment × (Capital IME Adjustment Factor + Capital DSH

Adjustment Factor) = IME and DSH
Outlier Adjustment

4. On page 43227, in the first column, at the end of Step 2: Determination of Capital Cost Thresholds, the following note is added:

"Note: To be eligible for cost outlier payments, the combined capital and operating standardized costs must exceed the appropriate combined cost outlier thresholds."

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES

5. On page 43241, the authority citation for part 413 is revised to read as follows:

Authority: Secs. 1102, 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395g, 13951(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); sec. 104(c) of Pub. L. 100-360 as amended by sec. 608(d)(3) of Pub. L. 100-485 (42 U.S.C. 1395ww (note)); and sec. 101(c) of Pub. L. 101-234 (42 U.S.C. 1395ww (note)).

§ 413.40 [Amended]

6. On page 43242, in the second column, in § 413.40(g)(1), beginning on line one, "HCFA must adjust the amount of the operating costs" is corrected to read "HCFA may adjust the amount of the operating costs."

7. On page 43245, in the second column, in the first paragraph, the proposed rural adjustment factor is changed from .999765 to .999766. In the second paragraph, the final rural adjustment factor is changed from .999766 to .999765.

8. On page 43274, in Table 4a, in the third column, the wage index value for Champaign-Urbana-Rantoul, IL is changed from .8757 to .8753.

9. On page 43275, in Table 4a, in the third column, Perry, PA is added to the list of counties in the Harrisburg-Lebanon-Carlisle, PA urban area.

10. On page 43277, in Table 4a, in the second column, the asterisk beside Owensboro, KY is removed because this urban area is not a large urban area.

11. In Table 4c, beginning on page 43279, the following changes are made in wage index values for hospitals that are reclassified:

Area reclassified to	Wage index
Albany, GA.....	.7770
Fayetteville, NC.....	.7886
Little Rock-North Little Rock, AR.....	.8250

Area reclassified to	Wage index
Rockford, IL.....	.9103
Santa Rosa-Petaluma, CA.....	1.2968
Sharon, PA.....	.9074
Tyler, TX.....	.9288

12. On page 43296, in Table 6a-New Diagnosis Codes, in the 16th line, for new diagnosis code 76.3, Kaposi's sarcoma, gastrointestinal sites, "Y" is changed to "N" in the complications or comorbidities (CC) column.

13. On page 43346, in the first column, under section II, beginning on the fourth line, "and thus, were part of the initial impact analysis" is changed to read, "and thus were not part of the initial impact analysis."

14. On page 43346, in the third column, under section IV, on line 2, the number of Medicare hospitals currently paid on a reasonable cost basis is changed from 990 to 706. On line three, the number of hospital units paid on a reasonable cost basis is changed from 1,820 to 1,830.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance)

Dated: November 19, 1991.

Fred Wirth,

Acting Deputy Assistant Secretary for
Information Resources Management.

[FR Doc. 91-28239 Filed 11-22-91; 8:45 am]

BILLING CODE 4120-01-M

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

43 CFR Public Land Order 6910

[MT-930-4214-10; MTM 41523]

Partial Revocation of Executive Order Dated April 17, 1926; Montana

AGENCY: Bureau of Land Management, Interior.

ACTION: Public Land Order.

SUMMARY: This order revokes an Executive order insofar as it affects 40 acres of public land withdrawn for use as a public water reserve. The land is no longer needed for that purpose, and the revocation is needed to permit disposal of the land through land exchange under section 206 of the Federal Land Policy and Management Act of 1976. This action will open the land to surface entry and nonmetalliferous mining unless closed by overlapping withdrawals or temporary segregations of record. The land has been and

remains open to metalliferous mining and mineral leasing.

EFFECTIVE DATE: December 26, 1991.

FOR FURTHER INFORMATION CONTACT:

James Binando, BLM Montana State Office, P.O. Box 36800, Billings, Montana 59107, 406-255-2935.

By virtue of the authority vested in the Secretary of the Interior by section 204 of the Federal Land Policy and Management Act of 1976, 43 U.S.C. 1714 (1988), it is ordered as follows:

1. The Executive Order dated April 17, 1926, which created Public Water Reserve No. 107, is hereby revoked insofar as it affects the following described land:

Principal Meridian

T. 14 s., R. 6 W.,

Sec. 19, SW ¼ SE ¼.

The area described contains 40 acres in Beaverhead County.

2. At 9 a.m. on December 26, 1991, the land will be opened to the operation of the public land laws generally, subject to valid existing rights, the provisions of existing withdrawals, other segregations of record, and the requirements of applicable law. All valid applications received at or prior to 9 a.m. on December 26, 1991, shall be considered as simultaneously filed at that time. Those received thereafter shall be considered in the order of filing.

3. At 9 a.m. on December 26, 1991, the land will be opened to location and entry under the United States mining laws for nonmetalliferous minerals, subject to valid existing rights, the provision of existing withdrawals, other segregations of record, and the requirements of applicable law. Appropriation of land described in this order under the general mining laws prior to the date and time of restoration is unauthorized. Any such attempted appropriation, including attempted adverse possession under 30 U.S.C. 38 (1988), shall vest no rights against the United States. Acts required to establish a location and to initiate a right of possession are governed by State law where not in conflict with Federal law. The Bureau of Land Management will not intervene in disputes between rival locators over possessory rights since Congress has provided for such determinations in local courts. Dated: November 7, 1991.

Dave O'Neal,

Assistant Secretary of the Interior.

[FR Doc. 91-28175 Filed 11-22-91; 8:45 am]

BILLING CODE 4310-DN-M

GENERAL SERVICES ADMINISTRATION

48 CFR Part 519

[APD 2800.12A Chge 30]

General Services Administration Acquisition Regulation; Earlier Review of Subcontracting Plans

AGENCY: Office of Acquisition Policy,
GSA.

ACTION: Final rule.

SUMMARY: The General Services Administration Acquisition Regulation (GSAR) is amended by revising paragraph (c)(2) of § 519.704 to correct the citation, and by revising paragraph (a) of § 519.705-4 to establish procedures for the early submission of subcontracting plans to the agency small business technical advisor (SBTA) and Small Business Administration Procurement Center Representative (SBA/PCR) in negotiated acquisitions and for consideration of their comments in negotiations. The intended effect is to improve the regulatory coverage and provide uniform procedures for contracting under the regulatory system.

EFFECTIVE DATE: November 27, 1991.

FOR FURTHER INFORMATION CONTACT: Paul Linfield, Office of GSA Acquisition Policy (202) 501-1224.

SUPPLEMENTARY INFORMATION:

A. Public Comments

This rule was not published in the *Federal Register* for public comment because it provides internal operating procedures to GSA contracting personnel regarding the timing for review of subcontracting plans by agency SBTA's and SBA/PCR's.

B. Executive Order 12291

The Director, Office of Management and Budget (OMB), by memorandum dated December 14, 1984, exempted certain agency procurement regulations from Executive Order 12291. The exemption applies to this rule.

C. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) does not apply because the proposed rule was not required to be published in the *Federal Register* for public comment.

D. Paperwork Reduction Act

Paperwork Reduction Act (44 U.S.C. 3501 et seq.) does not apply because this rule does not impose any recordkeeping or information collection requirement on offerors, contractors or other members of the public.

List of Subjects in 48 CFR Part 519

Government procurement.

1. The authority citation for 48 CFR part 519 continues to read as follows:

Authority: 40 U.S.C. 486(c).

PART 519—SMALL BUSINESS AND SMALL DISADVANTAGED BUSINESS CONCERNS

2. Section 519.704 is amended by revising paragraph (c)(2) to read as follows:

§ 519.704 Subcontracting plan requirements.

* * * * *

(c) *Duration of plans.*

* * * * *

(2) *Commercial products plans.* A commercial products plan is approved by the first Federal agency awarding a contract for commercial products during the contractor's fiscal year, and is applicable to every additional Federal contract for commercial products awarded to that contractor during the contractor's same federal year. If the approved plan is limited to a division or plant, it only applies to additional contracts for commercial products of that particular division or plant. The cutoff date for applying a previously approved commercial products plan to additional Federal contracts is the end of the company's fiscal year in which the plan was approved. If the contract extends beyond the contractor's fiscal year, the GSA contracting officer responsible for monitoring the existing plan, under § 519.706-70 (c) and (d), must request a new plan 30 days prior to the end of the contractor's fiscal year.

3. Section 519.705-4 is amended by revising paragraph (a) to read as follows:

519.705-4 Reviewing the subcontracting plan.

(a) Early review of the subcontracting plan by the SBTA is usually beneficial in expediting contract awards by eliminating last minute disagreements between the contracting officer and SBTA over the content or goals expressed in the subcontracting plan.

(1) In a negotiated acquisition, a copy of the subcontracting plan must be provided to the SBTA as soon as practicable after review by the contracting officer and before negotiating the plan. If the solicitation required subcontracting plans from all offerors, the contracting officer shall provide to the SBTA only the plans of firms in the competitive range.

(2) When providing the plan to the SBTA, the contracting officer shall establish a definite date (a minimum of 5

working days, unless a shorter period is agreeable to the SBTA, from receipt by the SBTA) by which the SBTA must submit comments. Oral comments may be accepted by the contracting officer when time restraints do not permit the SBTA to complete review on GSA Form 3584, Checklist for Review of Subcontracting Plan.

(3) The plan may be submitted to the SBA/PCR for concurrent review.

(4) Comments by the SBTA and/or SBA/PCR must be considered by the contracting officer in negotiating the plan and reasons for rejecting recommendations documented on GSA Form 3584 before submission of the plan to the SBTA and the SBA/PCR for final review. The contracting officer may award the contract if the SBTA and SBA/PCR have not completed their final review within 3 working days of the submission. In the case of an unresolved disagreement received during that period, the contracting officer must contact the Director, AU (see § 519.705-5(a)).

(5) Except as provided in (a)(2), above, GSA Form 3584 must be used by the procuring contracting officer (PCO) and SBTA when reviewing subcontracting plans. Its use by SBA procurement center representatives when reviewing plans is optional.

* * * * *

Dated: November 12, 1991.

Richard H. Hopf, III,
Associate Administrator for Acquisition
Policy.

[FR Doc. 91-28173 Filed 11-22-91; 8:45 am]

BILLING CODE 6820-61-M

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 630

[Docket No. 901197-1257]

RIN 0648-AD70

Atlantic Swordfish Fishery

AGENCY: National Marine Fisheries
Service (NMFS), NOAA, Commerce.

ACTION: Final rule.

SUMMARY: NMFS issues this final rule to amend the regulations implementing the Fishery Management Plan for Atlantic Swordfish (FMP). This rule: (1) Establishes as a condition for the renewal of an annual vessel permit in the Atlantic swordfish fishery that all fishing vessel reports required for that vessel must be submitted; and (2) adds

to the swordfish regulations a reference regarding the marine mammal exemption program under the Marine Mammal Protection Act, as it applies to vessels and persons in the longline and gillnet fisheries for swordfish. The intended effects of this action are: (1) to ensure that vessel reports necessary for the effective management of the swordfish fishery are received on a timely basis; and (2) to advise vessel owners and operators of additional Federal regulatory requirements that may apply to them.

EFFECTIVE DATE: December 26, 1991.

FOR FURTHER INFORMATION CONTACT: W. Perry Allen, 813-893-3722.

SUPPLEMENTARY INFORMATION: The Atlantic swordfish fishery is managed under the FMP and its implementing regulations at 50 CFR part 630 under the authority of the Magnuson Fishery Conservation and Management Act (Magnuson Act).

The regulations at 50 CFR 630.5(a) require an owner or operator of a permitted vessel that has been selected by the NMFS Science and Research Director to ensure that a daily fishing record is maintained on available forms. The forms must be submitted on a monthly basis to the appropriate NMFS Science and Research Director. Because many of these vessel reports have not been provided on a timely basis, NMFS proposed to condition the reissuance of the annual vessel permit required by 50 CFR 630.4 on the receipt of all vessel reports specified at 50 CFR 630.5(a) that were to be submitted for the 12 months immediately preceding the permit renewal application. The need for the required reports, and information on the implementation of the proposed action, were included in the proposal rule (55 FR 50199, December 5, 1990) and are not repeated here. Regulations issued under the Marine Mammal Protection Act of 1972, as amended (16 U.S.C. 1384) (Act), establish a 5-year exemption program (until October 1, 1993) from the Act's general prohibition on the taking of marine mammals for certain incidental takings of marine mammals in the course of commercial fishing (see 50 CFR part 229). Under the interim exemption program, the longline and gillnet fisheries for swordfish in the Atlantic Ocean (including the Gulf of Mexico and Caribbean Sea) have been identified as commercial fisheries in which there is an incidental taking of marine mammals. Accordingly, requirements including, but not limited to, registration, exemption certificates, decals, and reports as contained in 50 CFR part 229, apply to vessels, owners, and operators in those swordfish

fisheries. To ensure that swordfish longline and gillnet fishermen are aware of the requirements of the interim exemption program under the Act, section 630.3 of the swordfish regulations (Relation to other laws) is revised to reference 50 CFR part 229.

Comments and Responses

Comments

Comments were received from four individual swordfish fishermen and a fishermen's association. All of the comments addressed the proposed withholding of permits based on failure to submit all required reports.

Three commenters objected to the proposal because the receipt of November and December logbook reports would not be known by NMFS in time to issue permits for the following year and because NMFS does not have the ability to process vessel logbook reports on a "real-time" basis. Two commenters objected to NMFS "summarily" denying a fishing permit or withholding a renewal permit without warning that required logbook reports had not been received. One comment noted that 30 days is not sufficient time for an applicant to correct a deficiency in a permit application, including submission of delinquent reports, before an application is considered abandoned. The commenter noted that the distant-water nature of a portion of the swordfish fishing fleet might preclude timely receipt of notification and correction of a deficiency within 30 days. The commenter suggested 60 days as a more realistic time frame.

Response

The proposed rule clearly stated that NMFS was proposing to condition the processing of an application for a renewal permit on the receipt of a complete application and the receipt of all vessel reports identified at 50 CFR 630.5(a) that were due at the time of the application. NMFS has been, and intends to continue, issuing renewal permits during the last 2 months of the permit year—in the case of swordfish permits, the last 2 months of the calendar year. Therefore, determining whether all reports have been timely provided is based on the period preceding receipt of the renewal application. NMFS does not intend to delay the normal renewal of swordfish vessel permits.

Some of the commenters apparently do not understand clearly the "applicable reporting requirements of § 630.5(a)." The referenced paragraph, among other things, requires that fishing vessel logbook forms for each month

"must be submitted to the Science and Research Director so as to be received not later than the twenty-fifth day of the following month." Thus, prior to the twenty-fifth day of a month, the non-receipt by the Science and Research Director of a report for the preceding month does not constitute a failure to report on a timely basis.

NMFS is well aware that the recording of reports is not instantaneous upon their receipt. The recording of receipt of required fishing vessel reports may require up to 14 days from the deadline date for receipt of reports for a particular month. However, NMFS monitors its status of report recording so that NMFS is aware of any backlogs in recording the receipt of required fishing vessel reports. Accordingly, a month for which all timely submitted, required fishing vessel reports have not yet been recorded is not considered in determining the status of required reports. Because receipt of monthly fishing vessel reports is not required until the 25th day of the following month and recording of receipt may require up to 14 days, the status of a particular month's reports may not be available before the 39th day following that month. Thus, a period of approximately one month immediately preceding the renewal application is not considered when determining whether all reports have been timely filed.

As stated in the proposed rule, the Regional Director, Southeast Region, NMFS, will notify the applicant of a deficiency and the applicant will be given an opportunity to correct the deficiency. Thus, an annual vessel permit will not be summarily denied or withheld without warning.

NMFS concurs that, in the swordfish fishery, 30 days is not sufficient time for the correction of a deficiency in a permit application. Accordingly, as suggested, the period before an application will be considered abandoned is increased to 60 days.

The following schedule outlines the procedure that is being used to notify permit holders of reporting deficiencies and to issue renewal permits for 1992:

Late August 1991—Notification of 1991 permit holders regarding deficiencies in monthly reporting for the months of October 1990 through March 1991.

Mid-October 1991—Notification of 1991 permit holders regarding deficiencies in monthly reporting for the months of October 1990 through August 1991, and forwarding of preprinted applications for renewal of permits.

November and December 1991—Processing of renewal applications and issuance of 1992 permits for vessels for

which all applicable reporting requirements have been met.

When implementing this schedule, NMFS will examine whether the most recent vessel reports have been provided, i.e., an application received after mid-November will be reviewed based on the vessel reports through September and an application received after mid-December will be reviewed on the basis of the vessel reports through October.

For permits for 1993 and ensuing years, the mid-year notification of deficiencies is expected to be in June.

The telephone number and address of the office responsible for receiving and processing all swordfish fishing vessel logbook forms is provided in each set of logbook forms. Any questions regarding the status of a vessel's reports may be directed to that office.

NMFS believes that the procedures outlined above will provide timely notice regarding deficiencies in reporting and ample opportunity for correcting deficiencies. NMFS further believes that it is a reasonable exercise of an owner's authority and responsibility to ensure that all required vessel reports are submitted in a timely manner and, thus, ensure that the owner does not experience difficulty in having the vessel's permit renewed.

Changes from the Proposed Rule

As noted above, the period provided in 50 CFR 630.4(c)(2) for an applicant to correct a deficiency in an application for an annual vessel permit before the application is considered abandoned is changed from 30 to 60 days.

The proposed rule indicated that issuance of a permit was conditioned on the receipt of all vessel reports "for the 12 months immediately preceding the application." Based upon comments received, NMFS concluded that this phrase is confusing. Further, from the perspective of NMFS, the quoted phrase is overly restrictive. Receipt of these reports is essential to effective management without regard to time frame. Accordingly, the quoted phrase is removed from this final rule.

The "Issuance" paragraph (50 CFR 630.4(c)) is reworded for simplicity and clarity.

Classification

The Assistant Administrator for Fisheries, NOAA (Assistant Administrator), has determined that this rule is necessary for the conservation and management of the swordfish fishery and that it is consistent with the Magnuson Act and other applicable law.

The Assistant Administrator has determined that this rule is not a major rule requiring a regulatory impact analysis under E.O. 12291.

The General Counsel of the Department of Commerce has certified to the Small Business Administration that this rule will not have a significant economic impact on a substantial number of small entities. The primary effect of this rule is to increase the probability that fishermen will submit the required reports on a timely basis. The regulatory and economic impacts of the reporting requirements were fully evaluated when they were implemented (51 FR 20297, June 4, 1986). This rule will not change those previously assessed impacts.

This rule does not change any of the factors considered in the environmental impact statement prepared for the FMP; accordingly, this action is categorically excluded from the requirement of NOAA Directive 02-10 to prepare an environmental assessment.

In the final rule that implemented the FMP (51 FR 20297, June 4, 1986) NMFS concluded that, to the maximum extent practicable, the FMP is consistent with the approved coastal zone management programs of all the affected states. Since this rule does not directly affect the coastal zone in a manner not already fully evaluated in the FMP and the initial consistency determination, a new consistency determination under the Coastal Zone Management Act is not required.

This rule does not contain a collection-of-information requirement for purposes of the Paperwork Reduction Act.

This rule does not contain regulatory provisions with federalism implications sufficient to warrant preparation of a federalism assessment under E.O. 12612.

List of Subjects in 50 CFR Part 630

Fisheries, Fishing, Reporting and recordkeeping requirements.

Dated: November 19, 1991.

William W. Fox, Jr.

Assistant Administrator for Fisheries,
National Marine Fisheries Service.

For the reasons set forth in the preamble, 50 CFR part 630 is amended as follows:

PART 630—ATLANTIC SWORDFISH FISHERY

1. The authority citation for part 630 continues to read as follows:

Authority: 16 U.S.C. 1801 *et seq.*

2. Section 630.3 is revised to read as follows:

§ 630.3 Relation to other laws.

(a) The relation of this part to other laws is set forth in § 620.3 of this chapter and paragraph (b) of this section.

(b) In accordance with regulations issued under the Marine Mammal Protection Act of 1972, as amended, it is unlawful for a commercial fishing vessel, a vessel owner, or a master or operator of a vessel to engage in a longline or gillnet swordfish fishery in the Atlantic Ocean (including the Gulf of Mexico and Caribbean Sea) unless the vessel owner or authorized representative has complied with specified requirements including, but not limited to, registration, exemption certificates, decals, and reports, as contained in 50 CFR part 229.

3. In § 630.4, paragraph (c) is revised to read as follows:

§ 630.4 Vessel permits.

(c) *Issuance.* (1) The Regional Director will issue a permit at any time during the fishing year to an applicant if the application is complete. An application is complete when all requested forms, information, and documentation have been received and the applicant has submitted all applicable reports specified at § 630.5(a).

(2) Upon receipt of an incomplete application, the Regional Director will notify the applicant of the deficiency. If the applicant fails to correct the deficiency within 60 days of the date of the Regional Director's letter of notification, the application will be considered abandoned.

[FR Doc. 91-28254 Filed 11-21-91; 10:36 am]

BILLING CODE 3510-22-M

Proposed Rules

Federal Register

Vol. 56, No. 227

Monday, November 25, 1991

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

DEPARTMENT OF AGRICULTURE

Agricultural Marketing Service

7 CFR Part 1139

[DA-91-018]

Milk in the Great Basin Marketing Area; Notice of Proposed Suspension of Certain Provisions of the Order

AGENCY: Agricultural Marketing Service, USDA.

ACTION: Proposed suspension of rule.

SUMMARY: This notice invites written comments on a proposal to suspend for the period of December 1991 through August 1992 certain provisions of the Great Basin milk marketing order. The proposed suspension would remove the limits on the amount of milk that a producer-handler may purchase from pool plants or other order plants without losing its unregulated status. The same provisions were previously suspended for the period of December 1990 through August 1991 based on a public hearing held at Salt Lake City, Utah, on August 27-28, 1990.

DATES: Comments are due no later than December 2, 1991.

ADDRESSES: Comments (two copies) should be filed with the USDA/AMS/Dairy Division, Order Formulation Branch, room 2968, South Building, P.O. Box 96456, Washington, DC 20090-6456.

FOR FURTHER INFORMATION CONTACT: Clayton H. Plumb, Chief, Order Formulation Branch, USDA/AMS/Dairy Division, Order Formulation Branch, room 2968, South Building, P.O. Box 96456, Washington, DC 20090-6456, (202) 720-6274.

SUPPLEMENTARY INFORMATION: The Regulatory Flexibility Act (5 U.S.C. 601-612) requires the Agency to examine the impact of a proposed rule on small entities. Pursuant to 5 U.S.C. 605(b), the Administrator of the Agricultural Marketing Service has certified that this proposed action would not have a significant economic impact on a

substantial number of small entities. Such action lessens the regulatory impact of the Order on certain producer-handlers and tends to encourage more orderly marketing of milk in the Great Basin marketing area.

This proposed rule has been reviewed by the Department in accordance with Departmental Regulation 1512-1 and the criteria contained in Executive Order 12291 and has been determined to be a "non-major" rule under the criteria contained therein.

Notice is hereby given that, pursuant to the provisions of the Agricultural Marketing Agreement Act of 1937, as amended (7 U.S.C. 601-674), the suspension of the following provisions of the order regulating the handling of milk in the Great Basin marketing area is being considered for December 1991 through August 1992:

In § 1139.10(b)(1)(ii), the words "in an amount that is not in excess of the larger of 5,000 pounds or 5 percent of such person's Class I disposition during the month."

All persons who want to send written data, views or arguments about the proposed suspension should send two copies of them to the USDA/AMS/Dairy Division, Order Formulation Branch, room 2968, South Building, P.O. Box 96456, Washington, DC 20090-6456, by the 7th day after publication of this notice in the *Federal Register*. The period for filing comments is limited to 7 days because a longer period would not provide the time needed to complete the required procedures and include December 1991 in the suspension period.

The comments that are sent will be made available for public inspection in the Dairy Division during normal business hours (7 CFR 1.27(b)).

Statement of Consideration

The proposed suspension would make inoperative for the period of December 1991 through August 1992, the provision of the Great Basin milk order that limits the amount of milk that a producer-handler may purchase from pool plants and other order plants. A suspension was requested by Brown Dairy, Inc., a producer-handler located in Coalville, Utah, pending completion of action on several proposed amendments to the Great Basin order that were considered at a hearing held August 27-28, 1990, at Salt Lake City, Utah. Based upon that hearing record and written briefs, the

provision was suspended for the period of December 1990 through August 1991. Under the current provisions, the amount of milk that a producer-handler may buy monthly from pool plants or from other order plants to supplement its own production is limited to 5,000 pounds or 5 percent of its Class I sales, whichever is greater.

At the hearing Brown Dairy, Inc., supported its proposed amendment to relax the limits on producer-handler purchases from pool plants which is now under consideration. Proponent contends that the order's limit on purchases from regulated sources does not provide producer-handlers with sufficient flexibility in making seasonal sales to nearby winter ski resorts and summer camps. Brown Dairy also contends that a suspension of the limit on supplemental purchases during the higher production months of the year would not provide producer-handlers any competitive advantage because they would be required to pay the order's Class I price for such milk. Furthermore, producers under the Great Basin order would continue to receive the benefits of such Class I sales since such supplemental purchases would be from pool plants.

At the hearing and in comments filed after the hearing, Western Dairymen Cooperative, Inc., (WDCI) stated that the cooperative association was opposed to the suspension. WDCI stated that the current provision adequately allows a producer-handler to compensate for the seasonal nature of milk production by purchasing limited quantities of supplemental milk, from pool plants or other order plants and still maintain its exemption from pooling.

WDCI indicated that producer-handlers can market their own milk without sharing their Class I utilization with other producers. WDCI contended that producer-handlers have a competitive advantage over fully regulated distributing plants because they are not required to account to the producer-settlement fund at the Class I price for all their milk disposed in fluid form. WDCI stated that if a producer-handler, as in Brown's case, desires to expand its business beyond the capacity of this own production by bidding on contracts such as summer camps, that they should come under the same regulations as any other handlers.

Ideal Dairy, another producer-handler located in Richfield, Utah, testified briefly in support of Brown Dairy's proposal that would permit producer-handlers to purchase larger quantities of fluid milk than under the present regulations during nine months of the year.

Accordingly, it may be appropriate to suspend the aforesaid provisions for the period of December 1991 through August 1992.

List of Subjects in 7 CFR Part 1139

Milk marketing orders.

The authority citation for 7 CFR part 1139 continues to read as follows:

Authority: Secs. 1-19, 48 Stat. 31, as amended; 7 U.S.C. 601-674.

Signed at Washington, DC, on: November 18, 1991.

Daniel Haley,
Administrator.

[FR Doc. 91-28122 Filed 11-22-91; 8:45 am]

BILLING CODE 3410-02-M

NATIONAL CREDIT UNION ADMINISTRATION

12 CFR Parts 704 and 741

Corporate Credit Unions and Requirements for Insurance

AGENCY: National Credit Union Administration (NCUA).

ACTION: Proposed revision to regulation.

SUMMARY: On March 13, 1991, the NCUA Board (Board) issued proposed revisions to its regulations governing corporate credit unions and requirements for insurance (part 704 and § 741.9). The Board requested that comments be submitted on or before May 20, 1991. In response to subsequent requests, the Board extended the comment period to July 1, 1991. This proposal is a revision of the March 13 proposal and is based, for the most part, on the comments received. The rule is again being issued as a proposal to give all interested parties an opportunity to comment on provisions that were not part of the March 13 proposal, and also to allow for further comment on all aspects of the rule.

DATES: Comments must be received on or before January 9, 1992.

ADDRESSES: Send comments to Becky Baker, Secretary of the Board, National Credit Union Administration, 1776 G Street, NW., Washington, DC 20456.

FOR FURTHER INFORMATION CONTACT: D. Michael Riley, Director, or Ronald Alf, Corporate Credit Union Specialist, Office of Examination and Insurance (202) 682-9640, or Lisa Henderson, Staff

Attorney, Office of General Counsel (202) 682-9630, at the above address.

SUPPLEMENTARY INFORMATION:

A. Comments

The original due date for comments was May 20, 1991. The Board extended the comment period to July 1, 1991, in response to requests for an extension. See 56 FR 20567 (May 6, 1991). A total of 68 comment letters were received on the March 13 proposal, 56 FR 11952 (March 21, 1991): 14 from Federal corporate credit unions, 17 from State-chartered corporate credit unions, 23 from natural person credit unions, 7 from State credit union leagues, 2 from national credit union trade associations, 2 from state credit union regulators, 1 from a broker-dealer, 1 from a professional association representing certified public accountants, and 1 from a housing finance corporation. The majority of commenters generally approved of the proposal and expressed appreciation for the way in which NCUA worked with the corporate credit union community to develop it. Nearly every commenter, however, recommended one or more changes to the regulation. The specific comments and the Board's responses thereto are set forth below.

B. Section-by-Section Analysis

Section 704.1 Scope

Eleven commenters either supported or did not oppose NCUA's proposal to apply part 704 to all federally insured corporate credit unions. Seven commenters were opposed to proposed § 704.1, most of them stating that it represented an attempt to force federal regulations on state-chartered corporate credit unions, and that NCUA should respect the dual chartering system. The Board reviewed all of the comments and decided not to change the proposal. Corporate credit unions have approximately 35 percent of the investments of natural person credit unions. The vast majority of credit union members of corporate credit unions are federally insured. Accordingly, it is of vital concern to NCUA that corporate credit unions remain a safe and sound alternative for credit union investments. Consistent standards for corporate credit unions with respect to operating framework, reserving, and asset/liability management are essential to maintaining a viable system. In addition, part 704 regulates all federally insured corporate credit unions. Part 703 limits investments by federally insured credit unions to corporate credit unions which are examined by NCUA and are in substantial compliance with part 704. The combination of parts 703 and 704

will have the effect of requiring all corporate credit unions to follow part 704 in order to retain the deposits of federally insured credit unions.

Section 704.2 Definitions

Proposed § 704.2 provided a number of new definitions. This proposed revision clarifies certain definitions and adds several new ones.

Thirty-two commenters agreed with the proposal to include Membership Capital Share Deposit (MCSD) accounts in the definition of "capital," but two recommended adding "or equivalent" for instances in which the same type of account is called by another name. The Board has added the wording "or equivalent" to the regulation. The Board reserves the right to refuse to accept as "capital" MCSD accounts which differ significantly from the definition contained in the regulation.

Twenty-two commenters were in favor of the third element of the proposed definition of a corporate credit union, that it have a voting membership not less than 95 percent of which consists of credit unions. Twenty-three commenters were opposed to this element of the proposed definition. Nine stated that it would unnecessarily limit the number of associational members. One commenter argued that it would be impossible to comply with the requirement where the credit union base is small. In response to the comments, several changes have been made. Virtually all of the commenters were in favor of restricting "natural person" membership. Alleged abuses in the past were mainly due to soliciting natural person members to influence election results. The revised definition restricts natural person membership to the minimum required by State or Federal law to charter and operate the credit union. For example, pursuant to section 103 of the Federal Credit Union Act, 12 U.S.C. 1753, Federal credit unions must have at least seven natural person subscribers in order to be chartered. Therefore, under the proposed rule, federal corporate credit unions may only have seven natural person members. Although existing members may retain their membership, these remaining natural person members will no longer be allowed to vote once this regulation becomes effective. Finally, the proposed rule no longer requires that 95 percent of the members be credit unions.

Thirty commenters agreed with the proposed definition of MCSD accounts, although 17 objected to the proposal to make MCSD accounts mandatory where offered. On the other hand, seven commenters argued that MCSD accounts

should be a requirement for membership and that the words "where offered" should be deleted. They argued that if each corporate credit union is able to determine whether to require MCSD accounts as a condition of membership, there could be substantial differences in reserves of various corporate credit unions, which could cause confusion in the financial marketplace and damage the image of corporate credit unions. The Board never intended to require a corporate credit union to offer MCSD accounts or to require a corporate credit union's members to establish MCSD accounts if the corporate credit union offers such accounts. The definition of MCSD account has been changed to clarify that corporate credit unions are not required to offer such accounts.

One commenter questioned whether the annual disclosure of MCSD accounts was necessary, given the business relationship between corporate credit unions and their members. The Board believes that annual disclosure is necessary due to the unusual nature of the MCSD account.

The proposed rule has also been changed to require that if a member of a corporate credit union gives notice to withdraw its MCSD funds, it will have to wait 1 year before it can rejoin the corporate. This provision was added in order to provide an element of permanence which is a prerequisite of all "capital" accounts.

A definition of "net assets" was added to § 704.2 of the March 13 proposal in order to differentiate between total assets, which include all assets listed on the statement of position of the corporate credit union, and net assets, which exclude certain designated assets. In the initial proposal, the assets to be excluded were Central Liquidity Facility (CLF) stock subscriptions and member reverse repurchase transactions. Seven commenters suggested that CLF pass-through loans granted under authority of section 208 of the Federal Credit Union Act also be excluded from calculation of net assets. Eight commenters recommended that a corporate credit union's own reverse repurchase transactions, not just those for members, be excluded. CLF stock subscriptions and member reverse repurchase transactions are "pass-through" accounts which are excluded from assets because they have the effect of artificially inflating the balance sheet of the corporate credit union. Since CLF pass-through loans are guaranteed by the National Credit Union Share Insurance Fund (NCUSIF) and do not present any risk for a corporate credit

union, the Board agrees that they should be deducted from net assets. The definition has been modified accordingly. There is some risk with a corporate credit union's own reverse repurchase agreements and because of this risk, these assets were not excluded from the definition of net assets. In response to one commenter's confusion about the meaning of "member reverse repurchase transactions," a definition of that term has been provided.

In response to comments, definitions for "asset-backed securities," "material," and "foreign banks" were added. In addition, to clarify the investment regulation, a definition of "average life" was added. Finally, to clarify the newly proposed risk-based reserving system, the proposed regulation now includes definitions for "claims," "collateral for risk-reserving," "commitments," "credit equivalent amounts," "original maturity," "primary capital," "risk-based capital," "risk-weighted assets," "speculative activities," "term subordinated debt," "United States depository institutions," "United States Government or its agencies," and "United States Government-sponsored agency."

Section 704.3 Planning: Strategic and Business Plans

The Board initially proposed to require the development and adoption of written comprehensive business plans. Seven commenters agreed with the proposal, but several expressed concern that the supplementary information section defined the components of a plan too narrowly, limiting the discretion of the board and management in developing and implementing a plan. Twenty-two commenters objected to the proposal, generally on the grounds that such issues should be addressed in the examination process rather than in a regulation.

This section has been rewritten. The Board now proposes to require that officials prepare an annual strategic plan that defines the direction and operation of the corporate credit union, supported by detailed objectives and goals. Progress towards completing the goals should be reviewed periodically, and the strategic plan should be updated annually.

For material new services, products, investments, funds management strategy changes, fixed asset investments, etc., a comprehensive business plan must be developed. The business plan should include a cost analysis, a marketing analysis, advantages and disadvantages of the proposal, and alternatives. The plan should be as detailed and comprehensive as necessary to

adequately document the planning process that the officials of the corporate credit union went through before making their decision. To keep the plan current and viable, officials are expected to review and update the plan and supporting policies in writing at least annually and more often when the business plan is in its development stage.

The annual strategic plan will be reviewed for effectiveness by the corporate examiners at each examination contact. Business plans will be reviewed as appropriate. Management will be held responsible for making decisions within the parameters established by the plans.

Section 704.4 Asset/Liability Management

Nine commenters agreed with the proposal to require credit unions to develop and implement comprehensive written funds management policies, although one was uncertain how the requirement would be interpreted by various examiners. Three commenters were concerned about the specific requirements and their applicability to every corporate. Eight commenters opposed the proposal, arguing that it should not be part of the regulations. Two commenters contended that the Corporate Credit Union Network Standards and Guidelines (Standards and Guidelines) provide an adequate framework for a funds management policy.

The Board believes that effective asset/liability management is critical to the operation of each corporate credit union. Corporate credit unions are primarily an investment and liquidity facility and need to be prepared at all times to respond to foreseen and unforeseen demands of its members. Many of the past problems with corporate credit unions were the result of poor asset/liability management. This section was left open-ended in order to allow corporate credit unions to develop policies appropriate to the degree of interest rate risk and liquidity risk they have assumed.

Section 704.5 Capital Goals, Objectives and Strategies

Eight commenters were in favor of the proposal to require corporate credit unions to adopt formal, written goals, objectives, and strategies for the building of capital. Four commenters suggested that a cost-benefit analysis only be required a new activity would have a major effect on the corporate's capital. Two commenters suggested that the rule be amended by setting a de

minimis threshold, below which a cost-benefit analysis would not be required. Thirteen commenters disapproved of the proposal, arguing that it should not be part of the regulations.

The Board has agreed to change the proposed rule to clarify that a cost/benefit analysis and capital impact study would only be necessary prior to implementing an activity that would have a material impact on the corporate.

Section 704.6 Investment

Thirty-six commenters approved of the proposal to expand corporate investment powers, although many took issue with certain aspects of the proposed rule. In response to a comment regarding the authority to invest in credit union service organizations (CUSOs), the Board has modified the proposal to allow a corporate to request from the regional director a waiver of the 15 percent capital limitation.

Nine commenters stated that the proposed purchase and divestiture credit ratings were too high. In light of its desire for corporate credit unions to have low risk investment portfolios, the Board has determined not to lower the ratings. Three commenters objected to having higher credit standards for foreign banks than for domestic banks. The Board has decided to retain the proposed rating scheme until more information is learned about regulatory control over and other factors involving foreign banks. In response to a comment, however, the Board has added a short-term rating standard for foreign banks.

Two commenters proposed that corporate credit unions be permitted to establish a special reserve for investments downgraded below an "A" rating. The Board considered this suggestion but decided to allow the regional directors to determine when the establishment of a special reserve is a suitable alternative to divestiture. In response to comments, however, the Board has modified the divestiture requirement such that only downgraded investments of a "material" amount must be divested. A definition of "material" has been provided. Further, the Board has proposed to exempt from divestiture investments with a remaining maturity of 3 months or less.

In response to one comment, the Board wants to clarify that the rating requirements set out for corporate debt and certain asset-backed securities in paragraphs (iv) and (v) of § 704.6(b) § 704.6(b) (2) do not apply to obligations authorized for investment pursuant to section 107(7) of the Federal Credit Union Act and section 703 of the NCUA Rules and Regulations. The Board also

wishes to emphasize that corporate credit unions may not invest in debt securities that are convertible into common or preferred stock or any other type of security.

One commenter stated that corporate credit unions should not be prohibited from using interest-rate swaps, caps, and floors. Although not generally permissible or appropriate, the proposed corporate regulation does allow corporate credit unions to utilize interest-rate swaps, caps, and floors with regional director approval.

Finally, the Board has modified proposed § 704.6 to include limitations on corporate credit union investments in collateralized mortgage obligations (CMOs) and real estate mortgage investment conduits (REMICs). CMOs/REMICs, depending on many variables, can be either appropriate or unsuitable investments for corporate credit unions. Generally, they are subject to a higher degree of instrument risk than other investments that corporate credit unions are allowed to make. Instrument risk results from receiving unscheduled principal payments. Because corporate credit unions were chartered to be mainly a source of liquidity for the credit union system, it is inappropriate for corporate credit unions to assume a significant degree of instrument risk in order to achieve higher investment yields. A corporate credit union which has a significant concentration of CMOs/REMICs could incur unwarranted risk if it invests in fixed-rate CMOs/REMICs with long average lives (greater than 5 years) or have significant prepayment and extension risks. Investment expertise and sophistication is needed to safely invest a major part of a corporate credit union's assets in low risk CMOs/REMICs. The NCUA Board seeks to ensure that corporate credit unions which plan to commit significant percentages of their assets in CMOs/REMICs have the necessary expertise.

The Board also proposes to limit total CMO/REMIC investments to 30 percent of shares, less any shares created by member reverse repurchase agreements, plus capital. A corporate credit union exceeding this limit would not have to divest, but could not purchase additional CMOs/REMICs without the approval of the regional director until it is within the proposed 30 percent limit.

The limitations on CMOs/REMICs set forth in part 703 of this chapter still apply to variable-rate CMOs/REMICs. That is, a corporate credit union cannot invest in a CMO/REMIC whose average life would extend or is shortened by more than 6 years under modeling scenarios where mortgage commitment

rates immediately rise or fall 300 basis points unless the interest rate is reset at least annually, the maximum allowable interest rate on the instrument is at least 300 basis points above the interest rate of the instrument at the time of purchase, and the interest rate of the instrument varies directly (not inversely) with the index upon which it is based and is not reset as a multiple of the change in the related index.

Section 704.7 Lending

Twenty-two commenters were in favor of the proposed lending authority. In response to comments, the Board has rewritten paragraph (b)(1) to make it clearer and has modified paragraph (b)(3) to allow corporate credit unions to request authority to exceed the 15 percent limitation. In addition, the Board wishes to clarify that, with respect to loans to CUSOs, the 15 percent limitation is in the aggregate, not per CUSO.

Five commenters suggested that corporate credit union loan participations should be distinguished from those by natural person credit unions, and that corporate credit unions should be allowed to participate after disbursement of funds. The Board agrees and has added a provision on loan participations to the proposed regulation. This expanded loan participation authority will give the corporate credit unions additional options to meet future liquidity needs of credit unions.

In response to comments, the Board has authorized corporate credit unions to assess prepayment penalties on loans made at variable as well as fixed rates and has modified § 701.21(h)(1)(i)(E) of this chapter to exempt state-chartered corporate credit unions from the member business loan regulation.

Section 704.8 Borrowing

Fifteen commenters agreed with the proposal to allow corporate credit unions to borrow in any amount from any source. One commenter disagreed with the proposal, arguing that it was flawed by the liquidation payout priorities currently established by the NCUSIF. The commenter stated that if the proposed change is made, a corporate credit union could become highly leveraged and create undue risk to member credit unions as well as the NCUSIF. Creditors would not properly limit the amount a corporate borrowed because they would be in a senior position before share deposits and the NCUSIF if the corporate failed. The commenter argued that the payout priority established by NCUA for

creditors is the most significant factor considered by rating agencies when rating corporate credit union commercial paper. He stated that the proposed change unfairly places additional risk on member credit unions with shares on deposit at a corporate credit union. The Board has rewritten this section, proposing to cap a corporate's borrowing power at 10 times its capital. This should provide sufficient authority during most economic periods. If additional authority is needed, a corporate credit union can submit a request to its regional director.

The Board intends for corporate credit unions to borrow for the legitimate liquidity needs of its members and not for expansion.

Section 704.09 Services

Nine commenters agreed with the proposal, and except for minor rewording, it remains unchanged.

Section 704.10 Fixed Assets

Eleven commenters agreed and three disagreed with the proposal. One of those in disagreement argued that the limitation should be 25 percent of capital. Another stated that NCUA should remove investments in CUSOs from investments in fixed assets and should also remove the "arbitrary" percentage limitation on such investments. The Board has reviewed the comments and determined that the proposed provision is the best protection against excessive investment in fixed assets and CUSOs. A corporate credit union can apply to its regional director to exceed the limitations of this section.

Section 704.11 Corporate Reserves

Thirty-five commenters were opposed to the proposal, 29 of them supporting the risk-based reserve system developed by the Reserve Task Force of the Corporate Forum. The Board agrees that a risk-based reserving system is desirable and has studied the banking industry's international reserving system, known as the BASLE Accord. NCUA is proposing a risk-based reserving system for the corporate credit unions similar to the BASLE Accord. This system places more of an emphasis on the risk factors affecting corporate credit unions than does the present regulation or the March 13 proposal. For example, under this revised proposed rule, investments in direct obligations of the United States Government would not require any reserving, since there is no credit risk in these investments. However, investments in depository institutions that do not meet the minimum ratings set forth in this regulation would be reserved at 100

percent, since the credit risk would be much higher. Additional consideration was also given for interest rate and instrument risks.

The Reserve Task Force of the corporate forum provided valuable input and assistance into the development of the proposed risk-based reserving system, which is much more complex than the present system. It requires minimum acceptable capital levels and provides higher reserve transfers for the weaker capitalized corporate credit unions. It will allow corporate credit unions to have risk-based capital ratios equal to or exceeding comparable ratios of other financial institutions. The minimum ratio of risk-based capital to risk-weighted assets will be 8 percent for corporate credit unions. The median value of the top 100 commercial banks as of December 31, 1990, was 8.67 percent, with 22 banks falling below the 8 percent level. Generally, assets were assigned to risk-weighting categories in relation to credit risk. However, some assets that have a low credit risk but a very high interest-rate risk were assigned to the 100 percent category.

Section 704.12 Representation

(a) Board representation.

Twenty-seven commenters supported the proposal to require that at least three members of a corporate board be independent of any affiliated organization or interest. Twenty-nine commenters were opposed to the proposal. Fifteen stated or implied that it was undemocratic. Fourteen stated that other conflict provisions were sufficient to prevent abuse. Four stated that NCUA had sufficient enforcement and removal powers to act if a director failed to carry out the duties of obedience, loyalty, and diligence. Two stated that NCUA could meet its goal of ensuring democratic representation on corporate credit union boards by forbidding a person from gaining a board seat through designation.

This paragraph has been rewritten to address as many of the concerns of the commenters as possible. Under the revised proposal, a corporate credit union need not have three independent directors if it has open, independent elections. The proposed regulation includes criteria for such elections, including the institution of a reasonable nomination by petition process. The publication, Federal Credit Union Bylaw Amendments and Guidelines (NCUA 8001A) provides a number of alternatives which will satisfy these requirements.

(b) Representatives of organizational members.

This proposal is unchanged from the March 13 proposal.

(c) Recusal.

Eight commenters were in support of the proposal and eight were opposed. Several stated that it was not appropriate for a board member to be disqualified except for a direct conflict of interest where personal gain could be realized. The Board disagrees, believing recusal to be necessary even for an indirect conflict of interest. The Board notes, however, that recusal is generally not necessary for issues that apply to the general membership such as dividend declarations or loan policy changes. A provision has been added which specifies that where all of the directors are disqualified and the matter is substantive, the matter must be decided by the membership. A substantive matter would include, but not be limited to, the acquisition of a building or a computer system. In response to several comments, the Board wishes to clarify that when a director is disqualified from deliberating on or determining a particular matter, he or she is expected to leave the meeting.

Section 704.13 Annual Audit

Ten commenters agreed with the proposal. In response to comments, the proposal has been modified to clarify that copies of workpapers need not be given to NCUA examiners. However, they should be made readily available during examinations. Three commenters disagreed with the proposal. One commenter suggested that it be modified to require an independent CPA review of internal controls and security procedures on at least a biannual basis, with copies of reports provided to NCUA within 30 days of receipt. The internal review would be separate from and in addition to the annual audit requirement currently in the regulation. The Board agrees with the need for periodic internal control reviews. Internal controls are necessary to safeguard assets, improve the accuracy of records, ensure compliance with applicable laws, regulations, policies and procedures, and evaluate the efficiency of the operation. Internal controls should include, at a minimum, a budgetary process, recordkeeping procedures, a system of physical security, an organization chart and job descriptions, and appropriate segregation of duties. Since these responsibilities are regulated by § 701.12 of this chapter, however, they are not included here.

One commenter suggested exempting small institutions from the audit requirement, where it is determined that

the costs exceed the benefits. The Board has determined that the requirement should continue to apply to all corporate credit unions, since the smallest corporate has approximately \$20 million in assets and affects the interest of all member credit unions. Finally, in response to a comment that the term "management letter" is no longer used, the term "reportable conditions letter" has been added.

Section 704.14 Contracts/Written Agreements

Eight commenters agreed with the proposal and one disagreed. Except for minor rewording, it remains unchanged.

Section 704.15 State-Chartered Corporate Credit Unions

One commenter stated that NCUA needed to clarify what changes, if any, it visualizes in its supervision of state-chartered corporate credit unions. NCUA will continue to work with the state supervisory authorities in supervising the state-chartered corporate credit unions.

Section 704.16 Effective Date

Four commenters approved of the proposed effective date of the regulation. One commenter stated that some federally chartered corporate credit unions in substantial compliance with the new regulation might wish to use the new investment powers prior to the expiration of the 6 month period and that provision should be made to authorize such activity. The proposal has been modified to allow corporate credit unions to use certain expanded authorities 30 days after the regulation is published in the **Federal Register** if they are in compliance with all other provisions of this part.

Three commenters disagreed with the proposed effective date. One commenter stated that the proposed definition of MCSA account would require re-marketing of such accounts to members in states where those deposits are not already subordinated to others.

However, as noted earlier, MCSA accounts are not required. The Board continues to believe that an effective date of 180 days after publication in the **Federal Register** is appropriate. Corporate credit unions that are unable to comply with certain provisions may apply for a temporary waiver.

Section 741.9

One commenter questioned the impact of this regulation on the dual chartering system. It is not NCUA's intention to limit the dual chartering system but to have a safe and sound corporate credit union system that is effectively and

consistently regulated. This change will have the effect of maintaining a consistent regulatory standard for all federally insured credit unions.

Regulatory Procedures

Regulatory Flexibility Act

The NCUA Board certifies that the proposed rule, if made final, will not have a significant impact on a substantial number of small credit unions (those under \$1 million in assets) because the rule applies only to the federally insured corporate credit unions, which number 33 nationally. All corporate credit unions have assets well in excess of \$1 million. Accordingly, the NCUA Board has determined that a Regulatory Flexibility Analysis is not required.

Paperwork Reduction Act

This proposed rule contains a requirement for the collection of additional information and a maintenance of documentation by a federally insured corporate credit union. The proposed regulation requires that each corporate credit union maintain a written strategic plan with goals and objectives to support the strategic plan, written policies, monthly monitoring reports, appropriate business plans and that federally insured state-chartered corporate credit unions obtain a CPA audit. Written investment and funds management policies, CPA audits and several monitoring reports are now required by the Corporate Credit Union Network Standards and Guidelines, by which the corporate credit unions voluntarily regulate themselves. Other requirements, such as loan policies, are being done under standard business practices. Several of the reports that will be required by this regulation will not add significantly to the paperwork burden, since they are currently being prepared by corporate credit unions.

Prior to submitting a final rule, the paperwork requirements will be submitted to the Office of Management and Budget for review under the Paperwork Reduction Act. Written comments on these requirements should be forwarded directly to the OMB Desk Officer at the following address: OMB Reports Management Branch, New Executive Office Building, room 3208, Washington, DC 20530, ATTN: Jerry Waxman.

Executive Order 12612

Executive Order 12612 requires NCUA to consider the effect of its actions on state interests. It states that: "Federal action limiting the policy-making discretion of the states should be taken

only where constitutional authority for the action is clear and certain, and the national activity is necessitated by the presence of a problem of national scope." The issue of corporate credit unions and their risks to federally insured credit unions are concerns of national scope. In order to enable NCUA and the NCUSIF to have an operable mechanism in place to ensure the safety and soundness of federally insured credit unions, this regulation is proposed. This regulation will apply to all federally insured corporate credit unions. The NCUA Board believes that the protection of the National Credit Union Share Insurance Fund warrants these new restrictions and that the increased restrictions in the proposed amendments will not unduly burden federally insured state-chartered corporate credit unions. This proposed rule does not impose additional costs or burdens on the states, nor does it affect the state's ability to discharge traditional state government functions. The benefits provided and protection afforded by the NCUSIF are the same for federally insured state-chartered corporate credit unions as for federally chartered corporate credit unions. It is protection afforded through a federal system. The responsibility for administering that system lies with the NCUA Board. The NCUA Board believes that all federally insured corporate credit unions should be subject to the same requirements. The NCUA Board, pursuant to Executive Order 12612, has determined that this rule may have an occasional direct effect on the states, on the relationship between the national government and the states, or on the distribution of power and responsibilities among the various levels of government. Further, the proposed amendments may supersede provisions of state law or regulation concerning federally insured state-chartered corporate credit unions which do not substantially meet the requirements of Part 704.

List of Subjects in 12 CFR Parts 704 and 741

Credit unions.

By the National Credit Union Administration Board on November 13, 1991.

Becky Baker,
Secretary of the Board.

For the reasons set forth in the preamble, 12 CFR Chapter VII part 704 is proposed to be revised to read as follows:

PART 704—CORPORATE CREDIT UNIONS

- Sec.
 704.1 Scope.
 704.2 Definitions.
 704.3 Planning: Strategic and Business Plans.
 704.4 Asset/Liability Management.
 704.5 Capital Goals, Objectives and Strategies.
 704.6 Investment.
 704.7 Lending.
 704.8 Borrowing.
 704.9 Services.
 704.10 Fixed Assets.
 704.11 Corporate Reserves.
 704.12 Representation.
 704.13 Annual Audit.
 704.14 Contracts/Written Agreements.
 704.15 State-Chartered Corporate Credit Unions.
 704.16 Effective Date.
 Authority: 12 U.S.C. 1762, 1766(a), 1781 and 1789.

§ 704.1 Scope.

This part establishes special rules for all federally insured corporate credit unions and grants certain additional authorities to federal corporate credit unions. Except to the extent that they are inconsistent with this part, other provisions of NCUA's Rules and Regulations (12 CFR part 700 *et seq.*) and the Federal Credit Union Act apply to federally chartered corporate credit unions and federally insured State-chartered corporate credit unions to the same extent that they apply to other federally chartered and federally insured State-chartered credit unions, respectively.

§ 704.2 Definitions.

Asset-backed securities (ABS) means all securities supported by installment loans or leases or by revolving lines of credit. This definition excludes those securities referred to in the financial markets as collateralized mortgage obligations (CMOs) and real estate mortgage investment conduits (REMICs).

Average daily assets means the daily average of net assets calculated on the basis of assets at the close of each day in the period.

Average life means the weighted average time to principal repayment with the amount of the principal paydowns (both scheduled and unscheduled) as the weights.

Capital means the total of all corporate reserves (regular or statutory reserves, as applicable), all undivided earnings and all membership capital share deposit (or equivalent) accounts.

Claims means loans or other debt obligations.

Collateral for risk-reserving means those items which are formally

recognized by the risk-based capital framework and include eligible shares and deposits in the lending corporate credit union, and securities issued or guaranteed by the U.S. Government or its agencies.

Commitments means any arrangement that obligates a corporate credit union to extend credit in the form of loans or lease financing receivables; to purchase loans, securities or other assets; or to participate in loans and leases. Commitments also include overdraft facilities, revolving credit, home equity, and mortgage lines of credit, and similar transactions.

Corporate credit union means a credit union that:

- (1) Is operated primarily for the purpose of serving other credit unions;
- (2) Is designated by the National Credit Union Administration as a corporate credit union; and
- (3) Limits natural person members to the minimum required by state or federal law to charter and operate the credit union.

Corporate reserves means regular or statutory reserves, as applicable, excluding all valuation allowances established to meet the full and fair disclosure requirements of section 702.3 of this chapter.

Credit equivalent amounts means the amount of off-balance sheet items multiplied by the credit conversion factor.

Credit union service organization (CUSO) means an organization that:

- (i) Exists primarily to meet the needs of its member credit unions; and
- (ii) Engages only in business activities relating to the daily operations of the credit unions it serves or provides services associated with the routine operations of credit unions.

Foreign bank means any bank that is not headquartered in the United States.

Material means an amount that exceeds 5 percent of the corporate credit union's capital.

Membership capital share deposit (MCSD) account means a subordinated share account that:

- (1) Is established, at a minimum, as a 12-month notice account;
- (2) Is limited to members;
- (3) Is not subject to share insurance coverage by the National Credit Union Share Insurance Fund (NCUSIF) or other deposit insurers; and

(4) In the event of liquidation, is payable only after satisfaction of all other claims against the liquidation estate, including claims of uninsured shareholders and the NCUSIF. In any event, an MCSD account shall not be repayable until notice that the account holder credit union intends to withdraw

from the corporate credit union, except in the case of a credit union that is placed into liquidation, is purchased and assumed, or is merged. A corporate credit union that offers MCSD accounts must terminate the membership of an account holder credit union that withdraws funds from its MCSD account. Such an account holder credit union cannot rejoin the corporate credit union until 1 year after funds have been withdrawn. A corporate credit union cannot receive MCSD accounts from another corporate credit union. MCSD accounts cannot be used to pledge borrowings. Corporate credit unions that issue MCSD accounts shall disclose, at least annually to their members, the terms and conditions under which such accounts are issued.

Member reverse repurchase transaction means a transaction in which a corporate credit union acting as an agent, on behalf of its member, lends its member's securities and is not obligated to indemnify the member against loss.

Net assets means total assets less Central Liquidity Facility (CLF) stock subscriptions, CLF loans guaranteed by the NCUSIF, and member reverse repurchase transactions.

Non credit union member means any member of a corporate credit union that is not chartered or licensed as a credit union.

Original maturity means the length of time between the date when a commitment is issued and the earliest date on which the corporate credit union can unconditionally cancel the commitment.

Primary capital means all corporate reserves and undivided earnings.

Risk-based capital means the total of primary capital and secondary capital.

Risk-weighted assets means the sum of total balance sheet assets and off-balance sheet credit equivalent amounts multiplied by their appropriate risk-weights.

Secondary capital means MCSD or equivalent accounts, allowance for loan and lease losses up to a maximum of 1.25 percent of risk-weighted assets, and term subordinated debt.

Speculative activities means the use of forwards, options, futures, or similar activities other than when used to reduce interest rate risk.

Term subordinated debt means debt of a corporate credit union that

- (1) Is unsecured,
- (2) Is not a deposit,
- (3) Is not insured by the National Credit Union Administration,
- (4) Is subordinated to general creditors and claims of depositors,

(5) has an original maturity of at least 7 years.

(6) is not redeemable prior to maturity except with the approval of NCUA.

(7) is ineligible as collateral for a loan, and

(8) is represented by a debt instrument which clearly states that it will absorb losses.

Undivided earnings means all forms of retained earnings, except

(1) corporate reserves (regular or statutory reserves, as applicable), and
(2) valuation allowances established to meet the full and fair disclosure requirements of § 702.3 of this chapter.

United States depository institutions means offices or branches (foreign and domestic) of federally insured banks and depository institutions chartered and headquartered in the United States, Puerto Rico, and U.S. territories and possessions. This includes banks, mutual or stock savings banks, savings or building and loan associations, cooperative banks, credit unions, international banking facilities of domestic depository institutions, and U.S. chartered depository institutions owned by entities outside of the United States.

United States Government or its agencies means the United States Government or instrumentalities of the United States whose debt obligations are fully and explicitly guaranteed as to the timely payment of principal and interest by the full faith and credit of the United States Government.

United States Government-sponsored agency means an agency originally established or chartered to serve public purposes specified by Congress, but whose obligations are not explicitly guaranteed by the full faith and credit of the United States Government.

§ 704.3 Planning: Strategic and business plans.

(a) The board of directors of a corporate credit union shall adopt a strategic plan with appropriate objectives and goals. This plan will be reviewed periodically during the year to determine that the goals are being accomplished. At least annually, the strategic plan will be reviewed and updated.

(b) A business plan will be prepared for any material expenditure in fixed assets, new products and services, or investments in a CUSO.

§ 704.4 Asset/liability management.

(a) *General.* Corporate credit unions shall develop and implement comprehensive written funds management policies.

(b) *Monitoring.* Corporate credit unions shall prepare monthly matching reports showing the degree of mismatch between the sources and uses of funds for the various timeframes.

§ 704.5 Capital goals, objectives and strategies.

(a) *General.* Corporate credit unions shall adopt formal, written goals (both long-term and short-term), objectives and strategies, including a budgetary process, for the building of capital.

(b) *Impact study.* Where a proposed new service or program, purchase or lease of a fixed asset, or investment in or loan to a CUSO has a material effect on a corporate credit union, the corporate credit union shall perform a cost/benefit analysis of the activity and a study of its impact on the capital position of the corporate credit union.

(c) *Monitoring.* Management will establish monitoring standards and procedures to periodically review and reassess the capital position of the corporate credit union and will document the review.

§ 704.6 Investment.

(a) *Policies.* A corporate credit union shall develop written investment policies which address, at a minimum:

(1) Risk diversification;
(2) Funds management strategies;
(3) Approved investment issuers, instruments, credit limits, credit ratings and list of permissible institutions;
(4) Approved list of broker/dealers;
(5) Authorization of and limitations on persons/committees making investments; and

(6) Procedures to periodically evaluate the quality of the investment portfolio.

(b) *Limitations.* (1) Credit Union Service Organizations (CUSOs). The aggregate of all investments in CUSOs shall not exceed 15 percent of a corporate credit union's capital unless permission is obtained from the regional director. A corporate credit union is prohibited from utilizing CUSO authority to acquire control, directly or indirectly, of another financial institution, or to invest in shares, stocks or obligations of another financial institution, insurance company, trade association, liquidity facility, or similar organization. Except to the extent that they are inconsistent with this paragraph, a corporate credit union investing in a CUSO shall adhere to the applicable provisions of paragraphs (c) through (e) of § 701.27 of this chapter.

(2) Other Investments. Corporate credit unions shall be limited to the following additional investments:

(i) Investments authorized by Sections 107(7), 107(8) and 107(15) of the Federal

Credit Union Act and Part 703 of this chapter, except where those authorities are inconsistent with other limitations of this section;

(ii) Deposits in state banks, trust companies, and mutual savings banks not domiciled in the state in which the corporate credit union does business;

(iii) Deposits and debt obligations of foreign banks subject to the following requirements:

(A) The bank must have assets of at least \$20 billion, and the investment must be rated not lower than A1 (or equivalent) for short-term (1 year or less) investments by a nationally recognized rating service, and not lower than AA— (or equivalent) for long-term (over 1 year) investments. Short-term investments downgraded below A2 (or equivalent) and long-term investments downgraded below A— (or equivalent), if material in amount, shall be divested;

(B) The investment shall be dollar-denominated;

(C) The country in which the investment is made shall be rated AAA (or equivalent) for political and economic stability; and

(D) Aggregate investments in any single foreign bank are limited to not more than 5 percent of the corporate credit union's net assets;

(iv) Debt obligations of U.S. bank holding companies and other U.S. chartered corporations rated A1 (or equivalent) for short-term investments (1 year or less) by a nationally recognized rating service and not lower than AA— (or equivalent) for long-term investments (1 year or more). Short-term investments downgraded below A2 (or equivalent) and long-term investments downgraded below A— (or equivalent), if material in amount, shall be divested. The total investment in the obligations of any single issuer shall not exceed 5 percent of the corporate credit union's net assets. This authority does not apply to debt obligations that are convertible into the stock of the corporation or holding company;

(v) Asset-backed securities subject to the following requirements:

(A) Rated not lower than AAA (or equivalent) by a nationally recognized rating service;

(B) Limited to a maximum of 5 percent of the corporate credit union's net assets for any single issuer; and

(C) Having an average life at the time of purchase not to exceed 5 years. Asset-backed securities downgraded below AA— (or equivalent), if material in amount, shall be divested;

(vi) Federally issued CMOs/REMICs and privately issued CMOs/REMICs as

defined in section 3(a)(41) of the Securities Exchange Act of 1934. CMOs and REMICs are limited further as follows:

(A) *Fixed-rate.* An investment in a fixed rate CMO/REMIC must have an expected average life at the time of purchase not to exceed 5 years given an immediate increase of 300 basis points in mortgage loan commitment rates at the time of purchase. This limitation does not apply where the security is purchased as an investment of reserves and undivided earnings or if principal payments of the investment are specifically matched to principal payments of a corresponding liability.

(B) *Variable-rate.* If the CMO/REMIC has a variable interest rate with a cap, then the lesser of the highest interest rate cap or the final interest rate cap during the expected average life at the time of purchase must be at least 200 basis points above the cost of the corresponding liability that it is matched against;

(C) *Divestiture.* Privately-issued CMO/REMIC securities downgraded below AA- (or equivalent) shall be divested;

(D) *Issuer Limitation.* Privately-issued CMO/REMIC securities shall not exceed 5 percent of the corporate credit union's net assets for any single issuer;

(E) *Overall Limitation.* Total CMO/REMIC securities shall not exceed 30 percent of the corporate credit union's shares, less any shares created by member reverse repurchase agreements, plus capital. A corporate credit union that exceeds this limitation may not invest in additional CMO/REMIC securities after the effective date of this regulation without approval from the regional director.

(vii) Additional investments provided the corporate credit union has obtained permission from the regional director.

(c) *Exclusion.* The requirements of this section to divest investments downgraded below the minimum acceptable ratings do not apply if there are 3 months or less until the stated maturity for the downgraded investment.

(d) *Divestiture Time Frame.* The corporate credit union has 10 business days to divest itself of any investment downgraded below the minimum credit ratings in this section or to request permission from its regional director to hold the investment.

§ 704.7 Lending.

(a) *Policies.* A corporate credit union shall develop written loan policies which address, at a minimum:

(1) Loan types and limits;

(2) Documentation for each loan and line of credit;

(3) Security;

(4) Analysis of financial and operational data;

(5) Monitoring standards; and

(6) Review and reassessment of the credit quality of the borrower.

(b) *General.* Each individual loan or line of credit limit will be determined after analyzing the financial and operational soundness of the applicant and the ability of the applicant to repay the loan. Loans are limited as follows:

(1) *Loans to credit union members.*

The maximum aggregate amount in loans and approved lines of credit to any one borrower, excluding pass-through and guaranteed loans from the CLF and the NCUSIF and member reverse repurchase transactions, shall not exceed the corporate credit union's capital or 10 percent of the corporate credit union's paid-in and unimpaired shares, deposits and capital, whichever is greater;

(2) *Loans to members that are not credit unions.* Loans and lines of credit to a member, other than a credit union or a credit union service organization, shall not be in excess of the members' shareholdings in the corporate credit union unless individual specific authority is obtained from the regional director;

(3) *Loans to credit union service organizations (CUSOs).* Loans to CUSOs shall not exceed 15 percent of the corporate credit union's capital unless permission is obtained from the regional director; and

(4) *Loans to non-member credit unions.* The total amount of loans to other credit unions shall not exceed 25 percent of the corporate credit union's paid-in and unimpaired capital and surplus.

(c) *Participation Loans with other corporate credit unions.* A corporate credit union is permitted to participate in a loan with another corporate credit union and must retain an interest of at least 5 percent of the face amount of the loan. The participation agreement may be executed at any time prior to, during, or after disbursement.

(d) *Prepayment penalties.* If provided for in the loan contract, a corporate credit union is authorized to assess prepayment penalties on loans made at fixed and variable rates to member credit unions or other organizations.

§ 704.8 Borrowing.

A corporate credit union may borrow up to 10 times its capital. Additional borrowing authority can be obtained from the regional director.

§ 704.9 Services.

A corporate credit union may provide services to its members involving investments, liquidity management, payment systems and correspondent services, unless otherwise prohibited by the NCUA Board or, in the case of a state-chartered corporate credit union, prohibited by state law. The corporate will maintain written agreements with vendors, other providers and users of all services.

§ 704.10 Fixed assets.

(a) *General.* A corporate credit union's ownership in fixed assets shall be limited as described in § 701.36 of this chapter, except that in lieu of paragraphs (c) (1)-(4) of § 701.36, paragraph (b) of this section applies.

(b) *Investment in Fixed Assets.* (1) No corporate credit union, without the prior written approval of the regional director, shall invest in fixed assets where the aggregate of all such investments exceeds 15 percent of capital.

(2) A corporate credit union shall submit such statements and reports as the regional director may require in support of any investment in fixed assets in excess of the limit specified in paragraph (b)(1) of this section.

(3) A corporate credit union shall submit requests to exceed the limitation of paragraph (b)(1) of this section to its regional director. If the corporate credit union does not receive notification of the action taken on its request within 45 calendar days of the date the request was received by the regional office, the corporate credit union may proceed with its proposed investment in fixed assets. If the regional director determines that the proposal will not adversely affect the corporate credit union, the regional director will respond in writing and an aggregate dollar amount or percentage of total capital will be approved for investment in fixed assets.

§ 704.11 Corporate reserves.

(a) *Minimum Capital Ratio.* Each corporate credit union shall maintain a minimum ratio of risk-based capital to risk-weighted assets of 8 percent, of which at least 4 percent shall consist of primary capital. Any corporate credit union that does not meet or fails to maintain the minimum capital ratios is expected to, within 90 days, develop and implement a plan acceptable to NCUA for achieving an adequate level of capital consistent with the provisions of this regulation. This plan shall be submitted to its regional director.

(b) *Exceptions.* The NCUA Board may modify a corporate credit union's reserve requirements under special

circumstances as determined by the NCUA Board.

(c) *Components of risk-based capital.* A corporate credit union's qualifying capital base consists of primary and secondary capital of which at least 50 percent shall be composed of primary capital.

(d) *Limitations.* Term subordinated debt shall not exceed 50 percent of secondary capital. Term subordinated debt with a remaining maturity of less than 1 year is excluded from secondary capital.

(e) *Procedures.* Balance sheet assets and credit equivalent amounts for off-balance sheet items are assigned to one of four risk-weight categories. The total dollar amount in each category shall be multiplied by the risk-weight assigned to that category. The sum of the four categories comprises risk-weighted assets.

(f) *Frequency.* Each corporate credit union shall calculate the ratio of capital to risk-weighted assets each month prior to payment of dividends. A record of such calculation shall be maintained.

(g) *Risk-weights for Balance Sheet Assets.* Each balance sheet asset shall be assigned a risk-weight of 0 percent, 20 percent, 50 percent, and 100 percent as follows:

(1) The 0 percent risk-weight category shall include any coin and currency owned by the corporate credit union, balances due from a Federal Reserve Bank, direct claims and portions of claims that are unconditionally guaranteed by the U.S. Government or its agencies, any claims collateralized by cash or eligible deposits and any asset accounts related to member reverse repurchase agreements as defined in section 704.2.

(2) The 20 percent risk-weight category shall include investments by corporate credit unions in other corporate credit unions, loans made by one corporate credit union to another corporate credit union, member reverse repurchase loans that do not qualify for the 0 percent category, claims on or portions of claims guaranteed by U.S. Government-sponsored agencies, portions of claims (including repurchase agreements) collateralized by U.S. Government agencies or U.S. government-sponsored agencies, asset-backed securities rated no lower than AAA with an average life of less than 3 years at the time of purchase, all fixed-rate CMOs/REMICs (excluding CMOs/REMICs collateralized by whole-loan mortgages) that comply with the 5 year average life requirement of section 6(b)(2)(vi) of this part, all floating rate CMOs/REMICs (excluding CMOs/REMICs collateralized by whole-loan

mortgages) that qualify under section 6(b)(2)(vi) of this part, and short-term and long-term claims on U.S. depository institutions and foreign banks which meet one of the following conditions:

(i) The institution has a short-term debt rating not lower than A-2 (or equivalent) by a nationally recognized rating service or;

(ii) The institution has a long-term debt rating not lower than A- (or equivalent) by a nationally recognized rating service or;

(iii) The institution has a Thomson Bankwatch (or equivalent) issuer rating of B/C or better.

(3) The 50 percent risk weight category shall include asset-backed securities rated no lower than AAA having a weighted average life greater than 3 years at the time of purchase and all CMOs/REMICs collateralized by whole-loan mortgages.

(4) The 100 percent risk-weight category shall include all assets not included in the above risk-weight categories. This category shall include loans to and investments in CUSOs and investments in fixed assets. In addition, the following securities shall be risk-weighted at 100 percent because of the interest-rate risk they present, although they would otherwise be included in the above risk-weight categories since they present little or no credit risk:

(i) Stripped mortgage-backed securities and residual interests of CMOs/REMICs.

(ii) Zero coupon securities with a maturity date more than 5 years from the settlement date for purchase of the security.

(h) *Other Considerations.* (1) An investment in the shares of a mutual fund is assigned to the risk category appropriate to the highest risk-weighted asset that the fund is permitted to hold. In addition, if the fund engages in speculative activities as defined in Section 704.2, then investments in the fund will be assigned to the 100 percent risk category.

(2) Accruals will be assigned the risk-weighting of the underlying asset that they represent.

(i) *Credit Conversion Factors for Off-Balance Sheet Items.* (1) The 100 percent credit conversion factor applies to such arrangements as:

(i) A corporate credit union lending its members' securities and indemnifying the member against loss, when these transactions are not included on the corporate credit union's balance sheet;

(ii) A corporate credit union lending its own securities which are not already included on its balance sheet;

(iii) A corporate credit union issuing direct credit substitutes such as financial standby letters of credit; or

(iv) A corporate credit union participating in other equivalent irrevocable arrangements that effectively guarantee repayment of financial obligations such as commercial paper, commercial or individual loans or other debt obligations, and standby or commercial letters of credit.

(2) The 50 percent credit conversion factor applies to commitments such as lines of credit to members and nonmembers and to other transaction-related contingencies such as unused portions of participation loans and any other unused portion of a line of credit commitment with an original maturity exceeding 6 months.

(3) The 0 percent credit conversion factor applies to unused portions of lines of credit with an original maturity of 6 months or less.

(j) *Risk-based Capital Ratios.* (1) The primary capital ratio is computed by dividing primary capital by total risk-weighted assets.

(2) The total capital ratio is computed by dividing the sum of primary capital and secondary capital by total risk-weighted assets.

(3) Month-end amounts will be used to calculate corporate credit union capital ratios.

(k) *Required Reserve Transfers.* The amount that a corporate credit union is required to transfer or set aside in corporate reserves is based on both the corporate credit union's primary and total capital ratios. Due to the asset volatility that is inherent in the operations of corporate credit unions, ranges of capital ratios have been established. These capital ratio ranges are then associated with one of six corresponding categories in determining the required reserve transfer. To qualify for a lower reserve transfer category, the capital ratios must fall in both the primary and total capital ratio ranges of the applicable category. The corporate credit union shall set aside an amount equal to the appropriate required reserve transfer percentage times the corporate credit union's average daily assets for the transfer period times the number of days in the transfer period divided by 365.

(1) Category 1 requires a corporate reserve transfer percentage of at least 25 basis points of average daily assets when either the primary capital ratio is less than 4 percent or the total capital ratio is less than 8 percent. A corporate reserve transfer percentage greater than 25 basis points of average daily assets is required if needed to bring either or both

of the capital ratios up to the minimum acceptable level.

(2) Category 2 requires a corporate reserve transfer percentage of 20 basis points of average daily assets when the primary capital ratio is between 4.01 and 6 percent or the total capital ratio is between 8.01 and 9 percent.

(3) Category 3 requires a corporate reserve transfer percentage of 15 basis points of average daily assets when either the primary capital ratio is between 6.01 and 8.0 percent or the total capital ratio is between 9.01 and 12 percent.

(4) Category 4 requires a corporate reserve transfer percentage of 10 basis points of average daily assets when either the primary capital ratio is between 8.01 and 10 percent or the total capital ratio is between 12.01 and 15 percent.

(5) Category 5 requires a corporate reserve transfer percentage of 5 basis points of average daily assets when either the primary capital ratio is between 10.01 and 12 percent or the total capital ratio percentage is between 15.01 and 18 percent.

(6) Category 6 requires a corporate reserve transfer percentage of 0 basis points when the primary capital ratio is greater than 12 percent and the total capital ratio percentage is greater than 18 percent.

(l) Corporate credit unions must provide reserves necessary for full and fair disclosure as specified in § 702.3 of the NCUA Rules and Regulations.

§ 704.12 Representation.

(a) *Board Representation.* The board shall be determined as stipulated in the corporate credit union bylaws, provided that:

(1) At least three directors must be individuals who are independent of any affiliated organization with which the corporate credit union is associated or;

(2) Steps must be taken to assure open, independent elections including the following:

(i) The institution of a reasonable nomination by petition process;

(ii) The use of mail balloting procedures in conducting elections (or equivalent procedures to ensure that all members are provided an opportunity to participate in the election process);

(iii) The appointment of a nominating committee which is composed of members who are independent of any affiliated organization.

(b) *Representatives of organizational members.* A member credit union or affiliated non credit union member of a corporate credit union may appoint one of its members or officials as a representative to the corporate credit

union. The representative shall be empowered to attend meetings, to vote and to stand for election on behalf of the member. No individual may serve as the representative of more than one organizational member in the same corporate credit union.

(c) *Recusal Provision.* No director, committee member, officer, agent or employee of a corporate credit union shall in any manner, directly or indirectly, participate in the deliberation upon or the determination of any question affecting his / her pecuniary interest or the pecuniary interest of any corporation, partnership, or association (other than this credit union) in which he/she is directly or indirectly interested. In the event of the disqualification of any director, the disqualified director shall withdraw from such deliberation or determination and, in such event, the remaining qualified directors present at the meeting, if constituting a quorum with the disqualified director or directors, may exercise with respect to this matter, by majority vote, all the powers of the board. Where all of the directors are disqualified and the matter is substantive, the matter must be decided by the membership. In the event of the disqualification of any member of the credit committee or the supervisory committee, the disqualified committee member shall withdraw from such deliberation or determination. Where all of the committee members are disqualified, the matter must be decided by the board of directors.

(d) *Rights of Natural Person Members.* Natural person members shall not have the right to vote on any issue pertaining to the corporate credit union.

§ 704.13 Annual audit.

(a) The supervisory committee of a corporate credit union shall cause an annual opinion audit to be made by an independent, duly licensed certified public accountant (CPA) and shall submit the audit report to the board of directors. A summary of the audit report shall be submitted to the membership at the next annual meeting;

(b) The CPA's audit workpapers shall be made available for review by the examiner during the examination;

(c) A copy of the audit report and reportable conditions letter (i.e., management letter) shall be submitted to the appropriate regional office of NCUA within 30 days after receipt by the board of directors.

§ 704.14 Contracts/written agreements.

Services, facilities, personnel or equipment shared with any party shall be supported by a written contract, with

the duties and responsibilities of each party specified and the allocation of service fee/expenses fully supported and documented.

§ 704.15 State-chartered corporate credit unions.

This Part does not expand the powers and authorities of any state-chartered corporate credit union, beyond those powers and authorities provided under the laws of the state in which it was chartered.

§ 704.16 Effective date.

This regulation is effective beginning December 26, 1991 or May 26, 1992, if the corporate credit union plans to use the expanded authorities of paragraphs 6, 7, and 8 and has complied with the other provisions of this Part. Any corporate credit union that is unable to comply with this regulation by the effective date shall obtain a temporary waiver from the regional director. To obtain a waiver, the officials of the corporate credit union shall, at least 90 days before the effective date of this regulation, explain in writing the nature of and reasons for the noncompliance, state a target date by which the corporate credit union will be in compliance with the regulation, submit any and all information requested by the regional director necessary to make a decision concerning the waiver and request, in writing, that a waiver of this regulation be granted. The regional director will respond in writing within 45 days of receiving all requested information necessary to make a decision.

PART 741—REQUIREMENTS FOR INSURANCE

1. The authority citation for part 741 continues to read as follows:

Authority: 12 U.S.C. 1757, 1766, 1781 through 1790. Section 741.11 is also authorized by 31 U.S.C. 3717.

2. Section 741.9 is amended by revising paragraphs (a)(3) and (b)(3) to read as follows:

§ 741.9 Criteria.

* * * * *

(a) * * *

(3) Special reserve for nonconforming investments. State-chartered credit unions (except state-chartered corporate credit unions) are required to establish an additional special reserve for investments if those credit unions are permitted by their respective state laws to make investments beyond those authorized in the Federal Credit Union

Act or the NCUA Rules and Regulations. State-chartered corporate credit unions are permitted to make only those investments that are in conformance with part 704 of the NCUA Rules and Regulations.

* * * * *

(b) * * *

(3) Investment policies which are within the provisions of applicable law and regulations, i.e., the Act and part 703 of this Chapter for Federal credit unions and the laws of the state in which the credit union operates for state-chartered credit unions, except state-chartered corporate credit unions. State-chartered corporate credit unions are permitted to make only those investments that are in conformance with part 704 of the NCUA Rules and Regulations.

* * * * *

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BILLING CODE 7535-01-M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 91-ANE-40]

Airworthiness Directives; Textron Lycoming LTS101 Turboshaft and LTP101 Turboprop Series Engines

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: This notice proposes to supersede an existing airworthiness directive (AD), applicable to Textron Lycoming LTS101 series Turboshaft and LTP101 series turboprop engines, which currently requires initial and repetitive inspections of all integrally cast power turbine (PT) rotors for blade cracking and removal of rotors containing a crack. This proposed action would eliminate one of the current inspection methods, add additional inspection requirements, identify affected PT rotor part numbers, and establish PT speed operating limitations. This proposal is prompted by the continued occurrences of PT blade separation events since issuance of the current AD. This condition, if not corrected, could result in engine power loss and uncontained release of engine fragments.

DATES: Comments must be received no later than December 30, 1991.

ADDRESSES: Send comments on the proposal in duplicate to the FAA, New England Region, Office of the Assistant

Chief Counsel, Attn: Rules Docket No. 91-ANE-40, 12 New England Executive Park, Burlington, Massachusetts 01803-5299, or deliver in duplicate to room 311 at the above address.

Comments may be inspected at the above location in room 311, between the hours of 8 a.m. and 4:30 p.m., Monday through Friday, except federal holidays.

The applicable service information may be obtained from Textron Lycoming, Technical Publications, Department 30V, 550 South Main Street, Stratford, Connecticut 06497, and Bell Helicopter Textron, P.O. Box 482, Fort Worth, Texas 76101. This information may be examined at the FAA, New England Region, Office of the Assistant Chief Counsel, 12 New England Executive Park, Burlington, Massachusetts.

FOR FURTHER INFORMATION CONTACT: John E. Golinski, Engine Certification Office, ANE-140, FAA, New England Region, Engine & Propeller Directorate, Aircraft Certification Service, 12 New England Executive Park, Burlington, Massachusetts 01803-5299 (617) 273-7121.

SUPPLEMENTARY INFORMATION: Interested persons are invited to participate in the making of the proposed rule by submitting such written data, views, or arguments as they may desire. Communications should identify the rules docket number and be submitted in duplicate to the address specified above. All communications received on or before the closing date for comments specified above will be considered by the Administrator before taking action on the proposed rule. The proposals contained in this notice may be changed in light of comments received.

Comments are specifically invited on the overall regulatory, economic, environmental, and energy aspects of the proposed rule. All comments submitted will be available, both before and after the closing date for comments, in the Rules Docket for examination by interested persons. A report summarizing each FAA/public contact, concerned with the substance of this proposal, will be filed in the Rules Docket.

Commenters wishing the FAA to acknowledge receipt of their comments submitted in response to this notice must submit a self-addressed, stamped postcard on which the following statement is made: "Comments to Docket No. 91-ANE-40". The postcard will be date/time stamped and returned to the commenter.

Discussion

On April 14, 1988, the FAA issued AD87-11-09, Amendment 39-5902 (53 FR 16386, May 9, 1988), which requires initial and repetitive dye or fluorescent penetrant inspections of all integrally cast PT rotors for blade cracking. Additionally, the AD requires the removal from service of cracked blades. This AD was prompted by twelve incidents of PT blade fracture events, one of which was uncontained. This condition, if not corrected, could result in power loss and uncontained release of engine fragments.

Since issuance of that AD, there have been additional engine failures due to PT blade separations. Investigation into the causes of these additional failures indicates the need to make certain changes to the current inspection requirements and operating limitations. Engines which incorporate the replaceable blade power turbine rotor are not affected by this problem and are therefore excluded from this AD.

This proposed AD would eliminate the dye penetrate check as an approved means of inspecting the PT blades and will require the more sensitive fluorescent penetrant inspection (FPI). A 300 PT cycle inspection interval requirement has also been added to supplement the recurring 50 hour inspection criteria currently required by AD 87-11-09. This new criteria will require inspection of the PT rotor at intervals not to exceed 50 hours time in service or 300 PT cycles in service, whichever occurs first since the previous inspection. The 300 PT cycle criteria accounts for blade crack propagation caused by transient operation.

This proposed AD would also define a PT operational speed avoidance range for LTS101 engines installed in the Bell 222 Helicopter. It has been determined that operating the PT rotor within certain critical speed ranges result in an excitation to the PT blades that can rapidly propagate an existing crack. Further analysis is currently underway to define PT speed range avoidance for LTP101 turboprop applications and for LTS101 engines installed in the Aerospatiale AS350 helicopter. The requirements for LTP101 turboprop applications and Aerospatiale AS350 helicopters may be addressed in further rulemaking.

The FAA has reviewed and approved the technical contents of Textron Lycoming Service Bulletin Nos. LT101-72-00-0093, Revision 5, dated January 15, 1990, LTS101C-72-00-0131, dated September 17, 1990, Bell Helicopter

Textron Alert Service Bulletin Nos. 222-90-57, dated December 21, 1990 and 222U-90-30 dated December 21, 1990, which describe the inspections and the speed avoidance ranges. These operating limitations have been coordinated with the FAA, Southwest Region, Rotorcraft Directorate.

Since this condition is likely to exist or develop on other engines of this same type design, an AD is proposed which would require periodic inspections of the PT rotor and define PT operating speed avoidance ranges in accordance with the service bulletins previously described.

There are approximately 935 LTS101 and LTP101 series engines of the affected design in the worldwide fleet. It is estimated that 368 engines in the domestic fleet would be affected by this AD, that it would take approximately 3.0 manhours per engine to accomplish the required actions, and that the average labor cost would be \$55 per manhour. Based on these figures, the total cost impact of the AD on U.S. operators is estimated to be \$60,720.

The regulations proposed herein would not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this proposal would not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

For the reasons discussed above, I certify that this action (1) Is not a "major rule" under Executive Order 12291; (2) is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A copy of the evaluation prepared for this action is contained in the Rules Docket. A copy of it may be obtained from the Rules Docket.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Safety.

The Proposed Amendment

Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration (FAA) proposes to amend 14 CFR part 39 of the Federal Aviation Regulations (FAR) as follows:

PART 39—[AMENDED]

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 1354(a), 1421 and 1423; 49 U.S.C. 106(g) (Revised Pub. L. 97-449, January 12, 1983); and 14 CFR 11.89.

§ 39.13 [Amended]

2. Section 39.13 is amended by removing Amendment 39-5902 (53 FR 16386, May 9, 1988), D 87-11-09 and by adding the following new airworthiness directive (AD):

Textron Lycoming: (Docket No. 91-ANE-40)

Applicability: Textron Lycoming LTS101 series turboshaft and LTP101 series turboprop engines installed on but not limited to, Aerospatiale AS350, Bell 222, MBB BK117 helicopters, Piaggio P166-DL3 and Airtractor AT302 airplanes.

Compliance Required as indicated, unless previously accomplished.

To prevent power turbine (PT) blade fracture, which could result in engine power loss, and uncontained release of engine fragments, accomplish the following:

(a) Perform a Type I, Method C fluorescent penetrant inspection of PT rotors with part numbers (P/N) 4-141-070-XX and P/N 4-143-010-XX, installed in engines, in accordance with the procedures in Textron Lycoming Service Bulletin (SB) Number LT101-72-00-0093, Revision 5, dated January 15, 1990, as follows:

(1) Inspect for blade cracks within 50 hours or 300 PT cycles in service, whichever occurs first, since accomplishing the last inspection performed in accordance with AD 87-11-09.

(2) Thereafter, reinspect for blade cracks at intervals not to exceed 50 hours time in service or 300 PT cycles in service, whichever occurs first, since last fluorescent penetrant inspection.

(3) Remove from service, prior to further flight, PT rotors in which blade cracks are found during the above inspections. Prior to returning to service, replace with serviceable parts.

Note: PT rotor cycle and counting methodology is addressed in Textron Lycoming SB No. LT101-71-00-0002, Revision 12, dated May 31, 1991.

(b) Perform a Type I, Method D fluorescent penetrant inspection of P/N 4-141-070-XX and P/N 4-143-010-XX rotors prior to installation into a PT module or prior to returning to service in accordance with the instructions given in Textron Lycoming SB Number LT101-00-0093, Revision 5, dated January 15, 1990. PT rotors in which blade cracks are found during this fluorescent penetrant inspection may not be returned to service.

(c) For PT rotors P/N 4-141-070-XX and P/N 4-143-010-XX installed in LTS101-650C-3, LTS 101-650C-3A, and LTS101-750C-1 series engines, avoid continuous operation at certain PT operating speeds in accordance with Textron Lycoming SB Number LTS101C-72-00-0131, dated September 17, 1990, Bell Helicopter Textron Alert SB 222U-90-30, dated December 21, 1990, and Alert SB 222-90-57, dated December 21, 1990, within 20

hours time in service after effective date of this AD, as follows:

(1) Avoid continuous engine operation at 97% to 98.5% power turbine (Np) speed, including autorotation and single engine operation. Operation in this speed band is only permitted for topping checks and when operations in this range are necessary to maintain safe flight.

(2) Install cockpit tachometer decal and add temporary rotorcraft flight manual supplement in accordance with Bell Helicopter Service Bulletin Numbers 222U-90-30 and 222-90-57.

(d) Aircraft may be ferried in accordance with the provisions of FAR 21.197 and 21.199 to a base where the AD can be accomplished.

(e) Upon submission of substantiating data by an owner or operator through an FAA Inspector (maintenance, avionics, or operations, as appropriate), an alternative method of compliance with the requirements of this AD or adjustments to the compliance schedule specified in this AD may be approved by the Manager, Engine Certification Office, Engine and Propeller Directorate, Aircraft Certification Service, FAA, 12 New England Executive Park, Burlington, Massachusetts.

All persons affected by this directive who have not already received the appropriate service documents from the manufacturer may obtain copies upon request to Textron Lycoming, Technical Publications, Department 30V, 550 South Main Street, Stratford, Connecticut 06497 and Bell Helicopter Textron, P.O. Box 482, Fort Worth, Texas 76101. These documents may be examined at the FAA, New England Region, Office of the Assistant Chief Counsel, room 311, 12 New England Executive Park, Burlington, Massachusetts.

Issued in Burlington, Massachusetts, on November 7, 1991.

Jack A. Sain,

Manager, Engine and Propeller Directorate, Aircraft Certification Service.

[FR Doc. 91-28305 Filed 11-22-91; 8:45 am]

BILLING CODE 4910-13-M

DEPARTMENT OF LABOR

Mine Safety and Health Administration

30 CFR Parts 48, 75, and 77

Training and Retraining of Miners

AGENCY: Mine Safety and Health Administration, Labor.

ACTION: Notice to extend period for public comment.

SUMMARY: Due to requests from the public, the Mine Safety and Health Administration (MSHA) is extending the period for public comment regarding its proposed rule for training and retraining of miners.

DATES: Written comments on the proposed rule must be received on or before January 24, 1992.

ADDRESSES: All comments should be sent to: Mine Safety and Health Administration, Office of Standards, Regulations, and Variances, Room 631, 4015 Wilson Boulevard, Arlington, Virginia 22203.

FOR FURTHER INFORMATION CONTACT: Patricia W. Silvey, Director, Office of Standards, Regulations, and Variances, MSHA, phone (703) 235-1910.

SUPPLEMENTARY INFORMATION: On September 24, 1991, MSHA published a proposed rule (56 FR 48376) revising the training and retraining standards for the mining industry. The comment period was scheduled to end on November 25, 1991.

In response to requests from the public, MSHA is extending the time for commenting on this proposed rule to January 24, 1992. All interested members of the mining community are encouraged to submit comments prior to that date.

Dated: November 15, 1991.

Edward C. Hugler,

Deputy Assistant Secretary.

[FR Doc. 91-28171 Filed 11-22-91; 8:45 am]

BILLING CODE 4510-43-M

DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 251

[DoD Directive 4175.1]

Sale of Government-Furnished Equipment of Materiel and Services to U.S. Companies

AGENCY: Office of the Secretary, Department of Defense (DoD).

ACTION: Proposed rule.

SUMMARY: 32 CFR part 251 (DoD Directive 1475.1) is proposed to be revised, primarily to incorporate changes to 10 U.S.C. 2208(i) and the Arms Export Control Act (22 U.S.C. 2770). These changes tend to broaden previous DoD authority to sell articles or services in support of U.S. commercial marketing efforts.

DATE: Written comments to this proposed rule must be received by December 26, 1991.

FOR FURTHER INFORMATION CONTACT: W. Wells, (703) 697-8108.

ADDRESSES: Forward comments to Director, Defense Security Assistance Agency, Attention: DSAA/OPS-E, Washington, DC 20301.

SUPPLEMENTARY INFORMATION:

List of Subjects in 32 CFR Part 251

Arms and munitions; Exports; Government property.

Accordingly, 32 CFR part 251 is proposed to be revised to read as follows:

PART 251—SALE OF GOVERNMENT-FURNISHED EQUIPMENT OR MATERIEL AND SERVICES TO U.S. COMPANIES

Sec.

- 251.1 Purpose.
- 251.2 Applicability.
- 251.3 Policy.
- 251.4 Definitions.
- 251.5 Responsibilities.
- 251.6 Procedures.

Authority: 10 U.S.C. 2208(i); 22 U.S.C. 2770.

§ 251.1 Purpose.

This part expands 32 CFR part 251 to implement changes to 10 U.S.C. 2208(i) and 22 U.S.C. 2770. It provides policy, assigns responsibilities, and prescribes procedures.

§ 251.2 Applicability.

This part applies to the Office of the Secretary of Defense (OSD), the Military Departments, the Chairman Joint Chiefs of Staff and Joint Staff, the Unified Commands, and the Defense Agencies (hereafter referred to collectively as "DoD Components"). The term "Military Services," as used herein, refers to the Army, Navy, Air Force, and Marine Corps.

§ 251.3 Policy.

(a) The Department of Defense executes the authority provided by 22 U.S.C. 2770 to sell to U.S. companies defense articles and defense services (hereafter also "items") in connection with proposed exports on a direct commercial basis pursuant to State Department licenses or approvals under International Traffic in Arms Regulation. The Department of Defense also executes the authority provided by 10 U.S.C. 2208(i), which applies only to working-capital funded Department of Army facilities that manufacture large caliber cannons, gun mounts, recoil mechanisms, ammunition, munitions, or components thereof.

(b) Sales under reference 22 U.S.C. 2770 may be authorized only if the following applies:

- (1) The items are of a type approved for foreign military sales (FMS).
- (2) Sale of a U.S. Company under this part would simplify and expedite the direct commercial sale involved.
- (3) The items are of the type that would be supplied to the prime contractor as Government-furnished equipment (GFE) or materiel (GFM) for

manufacture or assembly into end items for use by the Military Services, and have in fact been supplied as GFE or GFM in connection with any past or present DoD procurement of such end items.

(4) The other provisions of this part are complied with.

(c) Sales under 10 U.S.C. 2208(i) may be authorized by the Department of the Army only if the following applies:

(1) The article or related services are sold to a U.S. manufacturer, assembler, or developer.

(i) For use in developing new products, or

(ii) For incorporation into items to be sold to, or to be used in a contract with, an agency of the United States or a friendly foreign government.

(iii) For use in commercial products.

(2) The sale has been approved previously by the Deputy Assistant Secretary of Defense (Production Resources) (DASD(PM)), or a designee.

(3) The other applicable provisions of this part are complied with.

§ 251.4 Definitions.

(a) *Authorized purchasers under 22 U.S.C. 2770.* A company incorporated in the United States as defined in paragraphs (a)(3), in paragraphs (a)(2), and (a)(3), or in paragraph (a)(4), of this section.

(1) The existing prime contractor for the specific end item with a DoD contract for final assembly or final manufacture in the United States of the end item for use by the Military Service.

(2) A known DoD-qualified producer of the end item to be used by the Military Services, or one considered by the commanding officer of the Military Department procuring activity to be a responsible contractor for final assembly or final manufacture in the United States of the end item for use by the Military Services, and which is not debarred, ineligible, or suspended for defense procurement contracts.

(3) A U.S. manufacturer that has an approved license under the International Traffic in Arms Regulation, which provides for the use of GFE or GFM in the direct commercial export to a foreign country for the use of the armed forces of that country or international organization. The license shall identify the defense end item being sold and exported, the quantity and identification of concurrent and follow-on spares, end item delivery schedule, and name of the ultimate user.

(4) In the case of ammunition components, a known DoD manufacturer, assembler, or developer that is:

(i) A U.S. subcontractor (at any tier) to an authorized purchaser as defined in paragraphs (a)(1) and (a)(3) or this section or in paragraphs (a)(2) and (a)(3) of this section, or

(ii) A U.S. contractor or U.S. subcontractor with a foreign company that is supplying items to a friendly foreign government or international organization.

Provided in paragraphs (a)(4) (i) and (ii) of this section that the end items incorporating the ammunition components must be delivered directly to the friendly foreign government or international organization.

(b) *Authorized purchasers under 10 U.S.C. 2208(i).* A company incorporated in the United States as defined in paragraphs (b)(1) and (b)(2) of this section. Where export of an article from the United States is involved, paragraph (b)(3) of this section also applies.

(1) A known DoD-qualified manufacturer, assembler, or developer of articles, and which is not debarred, ineligible, or suspended for defense procurement contracts.

(2) A company considered by the commanding officer of the Military Department procuring activity to be a responsible contractor for the proposed work.

(3) A company exporting articles is restricted to sales to a friendly foreign government and must have an approved license under the International Traffic in Arms Regulation, which provides for use or sale of the article in the direct commercial export to a foreign country for use by the armed forces of that country. The license shall identify the article being sold and exported, the quantity and identification of items provided as concurrent and follow-on spares, item delivery schedule, and name of the ultimate user.

§ 251.5 Responsibilities.

(a) The *Under Secretary of Defense for Policy (USD(P))*, or designee, shall provide overall guidance regarding the sale of GFE or GFM to U.S. companies for commercial export.

(b) The *Director, Defense Security Assistance Agency (DSAAA)* shall determine priorities or make allocations between two or more competing foreign requirements.

(c) The *Assistant Secretary of Defense (Production and Logistics) (ASD(P&L))*, or designee, shall approve all sales under 10 U.S.C. 2208 in accordance with policies set forth in DoD Directive 4005.1.¹

(d) *The Secretaries of the Military Department:* (1) Shall execute the functions conferred upon the Secretary of Defense by 22 U.S.C. 2270.

(2) May redelegate the authority under 22 U.S.C. 2270, but such delegation may not be below the level of the commanding officer or head of a procuring activity of the Military Department responsible for procurement of acquisition of the applicable end item.

(e) *The Secretary of the Army:*

(1) Shall execute the functions conferred by 10 U.S.C. 2208(i).

(2) May delegate the authority under 10 U.S.C. 2208(i).

(f) *The Comptroller of the Department of Defense (C, DoD)* shall monitor pricing compliance and financial administration set forth under DoD 7290.3-M.²

§ 251.6 Procedures.

(a) *Articles and services authorized for sale under 22 U.S.C. 2270.* (1)

Defense items that currently are in fact being furnished (or have been furnished) by the U.S. Government as GFE or GFM to a U.S. company that is or has been under contract to the Department of Defense for final assembly or final manufacture into an end item for use by the Military Services.

(2) Defense services that are directly associated with the installation, testing, and certification of GFE that are or have been provided by the U.S. Government to a U.S. company in connection with the U.S. Government procurement of similar end items for use by the Department of Defense. Such defense services, including transportation (subject to paragraph (e)(3)(ii) of this section), may be performed only in the U.S. and only in support of the sale of defense articles under this part; that is, services alone may not be provided under this part.

(3) Defense items shall not be procured by the Department of Defense for sale under 22 U.S.C. 2270 if they are available to the authorized purchaser directly from U.S. commercial sources at such times as may be required to meet the delivery schedule of the authorized purchaser.

(b) *Articles and services authorized for sale under 10 U.S.C. 2208(i).* (1) Articles that can be manufactured by a working-capital funded Department of the Army industrial facility that manufactures large caliber cannons, gun mounts, recoil mechanisms, ammunition, munitions, or components thereof

without present or future interference with performance of the work by that facility for the Department of Defense or for a contractor performing for the Department of Defense.

(2) Services that are directly associated with the articles sold. Such services, including transportation (subject to paragraph (e)(3)(ii) of this section), may be performed only in the U.S. and only in support of the sale of articles under this part; that is, services alone may not be provided under this part.

(3) Articles shall not be sold by Army industrial facilities under authority of 10 U.S.C. 2208(i) if they are readily available to the authorized purchaser directly from a U.S. commercial source in a timely manner that meets the requirements of the purchaser.

(4) Nothing in this part shall be construed to affect the application of the export controls provided for in Section 38 of the Arms Export Control Act to items that incorporate or are produced through the use of an article sold under this part.

(c) *Pricing, financing, and accounting.*

(1) To afford U.S. companies the ability to conduct planning and marketing of items, Military Departments are authorized to provide cost and delivery scheduling data to authorized potential purchasers (see § 251.4) in advance of execution of a sales agreement. Such data shall be identified as estimates and shall not be binding on the U.S. Government. Efforts shall be made to provide accurate data.

(2) Actual sales of items shall be made in cash, with payment upon signature of the sales agreement by the representatives of the U.S. Government and the U.S. company. Payment shall be received by the U.S. Government in U.S. dollars upon such signature and shall precede procurement action by the U.S. Government or, in cases of stock sales, delivery to the authorized purchaser.

(3) Prices for sales from procurement or sales from DoD stocks, under 22 U.S.C. 2270 or 10 U.S.C. 2208(i), shall be established in accordance with DoD 7290.3-M. Prices to be charged shall be the same as those established for sales under the FMS Program of the same defense articles and services, to include all surcharges and accessorial charges applicable to FMS, including an amount for administration not less than the FMS administrative surcharge. Full replacement cost pricing shall be used for all sales of defense articles from DoD stocks and all diversions from DoD procurement. Sales prices under 10 U.S.C. 2208(i), will include the same appropriate surcharges and accessorial

¹ Copies may be obtained, at cost from the National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161

² Copies may be obtained by writing Defense Institute of Security Assistance Management, Attention: DISAM-DRP, Wright-Patterson Air Force Base, OH 45433.

charges that are applicable to sales under FMS. Sales to Federal customers other than Department of Defense shall be priced in accordance with chapter 26 of the DoD Accounting Manual, DoD 7220.9-M.³

(4) An obligation for a reimbursable procurement may not exceed the cash received from an authorized purchaser as prescribed in paragraph (c)(2) of this section. If there is an increase in the procurement contract cost, the purchaser shall be required to make additional cash payment to the Military Service to fund the contract fully, plus applicable surcharges, when such an increase is known. The cash received from an authorized purchaser as prescribed in paragraph (c)(3) of this section, must be sufficient to fund the replacement cost of defense articles shipped from DoD stocks.

(5) Accountability shall be in accordance with DoD 7290.3-M with reimbursements from sales being credited to the current appropriation, fund, or account of the selling agency. Surcharges on items sold, such as nonrecurring cost recoupment and the FMS administrative charge, shall be accountable as FMS surcharges under DoD 7290.3-M. Amounts collected for items sold shall be credited to accounts specified in paragraph 10402 of DoD 7290.3-M.

(d) *Establishment of priorities and allocations.* (1) Unless otherwise directed by the USD(P) in coordination with the ASD(P&L), sales are not authorized if they result in inventory stockage levels dropping below the established reorder points. Except as provided in Section 21(i) of the Arms Export Control Act, sales are not authorized if they constitute a withdrawal of assets from U.S. stocks that result in a significant adverse impact on the combat readiness of the Military Services.

(2) When procurement is required, or manufacture in Government-owned facilities is necessary, the Military Department concerned shall determine whether a sale will be concluded. Unless directed by DSAA (see paragraph (d)(3) of this section, the Military Department concerned is responsible for the establishment of priorities for item procurement or manufacture and for allocations and delivery. In determining production priorities and allocations, the Military Departments shall consider fully all existing DoD requirements for U.S. and other foreign requirements and normally

will schedule manufacture, allocation, and delivery on a first-in, first-out basis.

In making such determinations, the Military Departments shall be guided by DoD Directive 4410.6⁴ and related assignments of force activity designators by the Chairman, Joint Chiefs of Staff.

(3) If there are two or more competing foreign requirements, the Director, DSAA, shall determine priorities or shall make allocations. Such priorities or allocations for foreign requirements shall supersede determinations made by the Military Department under paragraph (d)(2) of this section.

(e) *Sales agreement.* (1) The sales agreement with the U.S. company will identify the company, the items and quantities being sold, the estimated availability of the items, whether from DoD stocks or procurement, the estimated price of the items, the end item into which the GFE or GFM item or items will be incorporated for resale, and the identity of the purchaser. If an export license from Department of State is approved, the foreign purchaser and the number and date of the munitions export license, or State Department approval, are also required.

(2) The sales agreement shall be approved by the appropriate Military Department's General Counsel, or designee, and shall as a minimum, indicate that the U.S. Government:

(i) Retains the right to cancel in whole or in part or to suspend performance at any time under unusual or compelling circumstances if the national interest so requires.

(ii) Provides no warranty or guarantee, either expressed or implied, regarding the items being sold.

(iii) Shall provide best efforts to comply with the delivery leadtime cited, but will incur no liability for failure to meet an indicated delivery schedule.

(iv) Shall use its best efforts to deliver at the estimated prices, but that the purchaser is obligated to reimburse the U.S. Government for the total cost if it is greater than the estimated price.

(3) Moreover, the sales agreement shall state that:

(i) Payment terms are cash, payable in advance, in accordance with paragraph (c)(2) of this section.

(ii) Delivery shall be "Free on Board (FOB) Point of Origin" with purchaser to arrange for continental U.S. (CONUS) transportation, except for sensitive or hazardous cargo that normally shall be shipped by way of the Defense Transportation Service (DTS) at rates established in DoD 7290.3-M.

(iii) The purchaser is responsible for both insurance coverage, if desired, and when applicable, ultimate customs clearance for export.

(iv) The purchaser is required to reimburse the U.S. Government for all costs incurred by the U.S. Government if the purchase agreement is canceled by the purchaser before delivery of the defense materiel or completion of defense services.

(v) The purchaser renounces all claims against the U.S. Government, its officers, agents, and employees arising out of or incident to this agreement, whether concerning injury to or death of personnel, damage to or destruction of property, or other matters, and will indemnify and hold harmless the U.S. Government, its officers, agents, and employees against any such claims of third parties and any loss or damage to U.S. Government property.

(vi) The U.S. company agrees to provide for protection of classified information and will require the agreement with the foreign government to provide for protection of U.S. classified information.

Dated: November 20, 1991.

L.M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 91-28238 Filed 11-22-91; 8:45 am]

BILLING CODE 3810-01-M

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Parts 51, 52, and 60

[FRL-4034-7]

Requirements for Preparation, Adoption, and Submittal of Implementation Plans; Approval and Promulgation of Implementation Plans; Standards of Performance for New Stationary Sources

AGENCY: Environmental Protection Agency (EPA).

ACTION: Reopening of public comment period for proposed WEPCO rulemaking.

SUMMARY: On June 14, 1991 (56 FR 27630), EPA proposed regulations clarifying the new source review (NSR) requirements of title I of the Clean Air Act as they pertain to electric utility steam generating units. The proposed rulemaking also clarifies the Agency's policy regarding utility pollution control projects and implements changes made by Congress in the 1990 Clean Air Act

³ See footnote 1 of § 251.5(c).

⁴ See footnote 1 to § 251.5(c).

Amendments regarding clean coal technology and repowering projects.

A congressional hearing on the proposed WEPCO rulemaking was held before the U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health and the Environment, on July 22, 1991. The transcript from this hearing has been added to the Docket (A-90-06) for this rulemaking. At this time, the EPA is reopening the comment period to receive additional comments on the WEPCO proposal and on the information contained in the transcript of the hearing.

In the August 16, 1991 Federal Register (56 FR 40843) notices extending the initial comment period for this rulemaking, the Agency indicated that when the subcommittee made the transcript of this hearing available, EPA planned to place the transcript in the rulemaking docket and to reopen the public comment period to receive comment on the transcript. Although the final transcript is not yet available, the Agency needs to proceed with the rulemaking in order to provide the regulated community with the guidance it needs to meet the requirements of the Clean Air Act.

The Agency recognizes that some parties wishing to comment on the proposed rule may not have submitted comments during the initial comment period, choosing instead to wait until the comment period was reopened. Consequently, EPA is reopening the comment period at this time to receive additional comments on the proposed rule. The Agency has also placed a draft of the hearing transcript in the docket and will receive comments on the information contained therein. If the final transcript is received from the subcommittee during the comment period, it will also be placed in the docket.

DATES: Written comments on the proposed rulemaking must be received by December 10, 1991.

ADDRESSES: Submit comments on the proposed rule (in duplicate, if possible) to: EPA Air Docket (LE-131), Environmental Protection Agency, Attn: Docket A-90-06, 401 M Street, SW., Washington, DC 20460.

Docket: Supporting information used in developing the proposed rule is contained in Docket A-90-06. This Docket is available for inspection and copying between 8:30 a.m. and 3:30 p.m., weekdays, at EPA's Air Docket (LE-131), room M-1500, 401 M Street, SW., Washington, DC 20460. A reasonable fee may be charged for copying.

FOR FURTHER INFORMATION CONTACT: Wm. Larry Elmore, Office of Air Quality Planning and Standards (MD-15), Research Triangle Park, North Carolina 27711, (919) 541-5433.

Dated: November 20, 1991.

Michael Shapiro,

Acting Assistant Administrator for Air and Radiation.

[FR Doc. 91-28315 Filed 11-22-91; 8:45 am]

BILLING CODE 6560-50-M

40 CFR Part 764

[OPTS-62089A; FRL-4004-8]

Proposed Ban on Acrylamide and N-methylolacrylamide Grouts

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule; extension of comment period and announcement of public hearing.

SUMMARY: Notice is hereby given that the period for filing public comment on the proposed regulation of acrylamide and N-methylolacrylamide (NMA) grouts (56 FR 49863, October 2, 1991) is extended, and that an informal public hearing on the proposed rule will be held in Washington, DC.

DATES: Public comments must be received on or before January 16, 1992. Written notice of intent to participate in the informal hearing must also be received on or before January 16, 1992. The exact date, time, and location of the informal public hearing may be obtained by contacting the Environmental Assistance Division at the telephone number listed under **FOR FURTHER INFORMATION CONTACT**.

ADDRESSES: Submit nonconfidential written comments, in triplicate, identified by the docket number OPTS-62089A, by mail to: TSCA Public Docket Office (TS-793), Rm. NE-G004, Office of Toxic Substances, Environmental Protection Agency, 401 M St., SW., Washington, DC 20460. See **SUPPLEMENTARY INFORMATION** for information on submitting comments containing confidential business information (CBI).

FOR FURTHER INFORMATION CONTACT: David J. Kling, Acting Director, Environmental Assistance Division (TS-799), Office of Toxic Substances, Environmental Protection Agency, Rm. E-543, 401 M St., SW., Washington, DC 20460. Telephone: (202) 554-1404. TDD: (202) 554-0551.

SUPPLEMENTARY INFORMATION: On October 2, 1991, EPA issued a Notice of Proposed Rulemaking on acrylamide

and N-methylolacrylamide (NMA) grouts (56 FR 49863). Written comments on the proposed rule were to be received on or before December 2, 1991. On October 16, 1991, Avanti International filed a request for an extension of the public comment period through March 2, 1992. Avanti International, the sole importer of acrylamide and NMA grouts, indicated that an extension would be necessary in order for it to adequately analyze and comment on the proposed rule. Mr. James T. Conklin filed a request for the scheduling of an informal public hearing.

EPA hereby grants an extension of time for the submission of public comments on this proposed rule. Written comments must be received on or before January 16, 1992. EPA believes that a 45-day extension of the public comment period will provide sufficient time for all interested parties to submit written comments on the proposed rule.

The informal public hearing will be held in Washington, DC, approximately 4 to 6 weeks after the close of the public comment period. This hearing will be conducted in accordance with EPA's "Procedures for Conducting Rulemaking under section 6 of the Toxic Substances Control Act" (40 CFR part 750). Persons or organizations desiring to participate in the informal hearing must file a written request to participate. The written request to participate must be sent to the Environmental Assistance Division at the address listed under **FOR FURTHER INFORMATION CONTACT**, and must be received on or before January 16, 1992. The written request to participate must include: (1) A brief statement of the interest of the person or organization in the proceeding; (2) a brief outline of the points to be addressed; (3) an estimate of the time required; and (4) if the request comes from an organization, a nonbinding list of the persons to take part in the presentation.

Organizations are requested to bring with them, to the extent possible, employees with individual expertise in and responsibility for each of the areas to be addressed. Organizations which do not file main comments in the rulemaking will not be allowed to participate at the hearing, unless the Record and Hearing Clerk grants a waiver of this requirement in writing.

Reply comments on the proposed rule must be received no later than 2 weeks after the close of all hearings, and must be restricted to comments on: (1) Other comments; (2) material in the hearing record; and (3) material which was not and could not reasonably have been available to the commenting party a

sufficient time before main comments were due.

Any person who submits written comments containing confidential business information (CBI) must mark the comments as "Confidential Business Information." Comments not claimed as confidential at the time of submission will be placed in the public file. Any comments marked as "Confidential Business Information" will be treated in accordance with the procedures in 40 CFR part 2. Any party submitting comments claimed to be CBI must prepare and separately submit a public version of the comments that EPA can place in the public file. CBI comments should be submitted in triplicate to: Document Control Office (TS-790), Office of Toxic Substances, Environmental Protection Agency, 401 M St., SW., Washington, DC 20460. CBI comments should be mailed in a double envelope with "CBI" and the docket number OPTS-62089A marked on the inner envelope, and the comments should be marked with docket number OPTS-62089A.

List of Subjects in 40 CFR part 764

Acrylamide, Environmental protection, N-methylolacrylamide, Recordkeeping and reporting requirements.

Dated: November 18, 1991.

Joseph A. Carra

Acting Director, Office of Toxic Substances.

[FR Doc. 91-28252 Filed 11-22-91; 8:45 am]

BILLING CODE 6560-50-F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 413

[BPD-366-CN]

RIN 0938-AD01

Medicare Program; Clarification of Medicare's Accrual Basis of Accounting Policy

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Proposed rule; correction.

SUMMARY: In the October 9, 1991 issue of the *Federal Register* (56 FR 50834), we proposed clarifications to the concept of "accrual basis of accounting". This notice corrects an inadvertent error made in the document.

FOR FURTHER INFORMATION CONTACT: Anthony Coates, (301) 966-4515.

SUPPLEMENTARY INFORMATION:

We are making the following correction to the October 9, 1991 document.

§ 413.24 [Amended]

On page 50837, in the third column, in § 413.24(c)(3)(iii)(B), at the end of the fourth line of paragraph (B), "bills for the cost of goods and services." is added.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance)

Dated: November 19, 1991.

Fred Wirth,

Acting Deputy Assistant Secretary for Information Resources Management.

[FR Doc. 91-28241 Filed 11-22-91; 8:45 am]

BILLING CODE 4120-01-M

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

43 CFR Part 3260

[WO-601-4141-24 1A]

RIN 1004-AB90

Geothermal Resources Operations

AGENCY: Bureau of Land Management, Interior.

ACTION: Proposed rule.

SUMMARY: This proposed rule would amend this section governing appeals of decisions relating to geothermal resources operations to allow an authorized officer's decision to remain in effect during the pendency of an appeal. The amendment is needed to allow the Secretary of the Interior (Secretary) to determine whether the issues involved in an appeal warrant a stay of geothermal resources operations and the accompanying delays and economic consequences.

DATES: Comments should be submitted by January 24, 1992. Comments received or postmarked after the above date may not be considered in the decisionmaking process on the final rule.

ADDRESSES: Comments should be sent to:

Director (140), Bureau of Land Management, room 5555, Main Interior Building, 1849 C Street, NW., Washington, DC 20240. Comments will be available for public review at the above address during regular business hours (7:45 a.m. to 4:15 p.m.), Monday through Friday.

FOR FURTHER INFORMATION CONTACT: Douglas Koza, (202) 653-2136.

SUPPLEMENTARY INFORMATION: Under the existing regulations governing geothermal resources operations,

decisions of the authorized officer to approve geothermal exploration, development, and production activities are subject to an automatic stay upon the filing of an appeal by any party. The current geothermal regulations at 43 CFR 3266.1 provide that appeals of decisions of the authorized officer are handled under 43 CFR part 4. Part 4 provides that an appeal stays the decision of the authorized officer until a decision is issued by the Interior Board of Land Appeals (IBLA), whether the appeal has merit or not. The regulations do not provide the Secretary the opportunity to determine whether the issues involved in an appeal warrant a stay of the decision. Such stays can have and have had serious financial impacts on operators, by making it difficult or impossible for them to meet rigid sales contract deadlines to begin electrical generation. Delays in beginning construction and other operations caused by stays due to appeals typically result in a significant economic impact. Even worse is the situation in which permitted operations must be discontinued due to the appeal. Such situations can lead to the cancellation of an entire project. The IBLA routinely takes 9 months or more to decide appeals, and even expedited reviews by IBLA can take 6 months or more. The length of this review period by itself may prevent an operator from meeting the performance provision of the sales contract. Project delay or cancellation also may reduce or eliminate royalty income to the Federal Government and States and present or needlessly delay development of a clean domestic energy source. Recent and current world events make it more imperative than ever that the United States develop clean alternative energy sources in an environmentally sound manner to reduce its reliance on foreign oil.

These operators have, in good faith, properly applied to the Bureau of Land Management (BLM) under the regulations for approval to conduct activities. However, after their application proceeds through required public participation and compliance with the National Environmental Protection Act by the BLM, they are prevented from acting on BLM's approval by an appeal that may be frivolous. Under the current regulation, any approved activities begun within 30 days of the approval date are required to discontinue operations upon the filing of any appeal, regardless of the merit of the issue.

The BLM's permit approval process, in accordance with the regulations at 43 CFR 3261.3(b)(4), requires public as well

as State and other Federal agency input, review, and comment on the environmental review process. This process is designed to identify and fully address all concerns over proposed operations, determine whether the proposed operation will be approved, and require adequate environmental and public health and safety protection measures of the operator. It is unlikely that there would be any unidentified, significant potential impacts raised in an appeal that would have not already been assessed and mitigated by the time a proposal is approved.

This rule would amend the "Appeals" section at 43 CFR 3266.1 to provide that a decision of the authorized officer remains in full force and effect during the pendency of an appeal, unless otherwise determined by the Secretary, and to state how petitions for stay of decisions may be filed. The amendment would provide the Secretary the opportunity to determine whether the issues raised in an appeal, especially with regard to the environmental sensitivity of the area affected and the potential for significant environmental or public health and safety impact, warrant a stay of the approval until IBLA rules on the appeal.

The principal author of this proposed rule is Douglas Koza, Division of Fluid Mineral Lease and Reservoir Management, assisted by the staff of the Division of Legislation and Regulatory Management.

It is hereby determined that this proposed rule does not constitute a major Federal action significantly affecting the quality of the human environment, and that no detailed statement pursuant to section 102(2)(C) of the National Environmental Policy Act of 1969 (42 U.S.C. 4332(2)(C)) is required.

The Department of the Interior has determined under Executive Order 12291 that this document is not a major rule, and under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) that it will not have a significant economic impact on a substantial number of small entities. Additionally, as required by Executive Order 12630, the Department has determined that the rule would not cause a taking of private property.

This rule does not contain information collection requirements that require approval by the Office of Management and Budget under 44 U.S.C. 3501 *et seq.*

List of Subjects for 43 CFR Part 3260

Environmental protection, Geothermal energy, Government contracts, Public lands-mineral resources, Reporting and recordkeeping requirements.

For the reasons stated in the preamble, and under the authorities cited below, part 3260, Group 3200, subchapter C, chapter II of title 43 of the Code of Federal Regulations is proposed to be amended as set forth below.

PART 3260—GEOTHERMAL RESOURCES OPERATIONS

1. The authority citation for 43 CFR part 3260 is revised to read as follows:

Authority: Geothermal Steam Act as amended (30 U.S.C. 1001-1025).

Subpart 3266—Appeals

2. Section 3266.1 is revised to read as follows:

§ 3266.1 Appeals.

(a) A party adversely affected by a decision of the authorized officer may appeal that decision to the Interior Board of Land Appeals as set forth in part 4 of this title.

(b) All decisions of the authorized officer under this part shall remain effective pending appeal unless the Secretary rules otherwise upon consideration of the public interest, and the provisions of 43 CFR 4.21(a) shall not apply to such decisions. Petitions for stay of decisions shall be filed with the Interior Board of Land Appeals, Office of Hearings and Appeals, Department of the Interior.

Dated: September 24, 1991.

Richard Roldan,

Deputy Assistant Secretary of the Interior.

[FR Doc. 91-28227 Filed 11-22-91; 8:45 am]

BILLING CODE 4310-84-M

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 663

[Docket No. 911174-1274]

Pacific Coast Groundfish Fishery

AGENCY: National Marine Fisheries Service (NMFS), NOAA, Commerce.

ACTION: Proposed rule, and request for comments.

SUMMARY: NOAA issues this proposed rule to establish an opening date for the Pacific whiting season in the exclusive economic zone off Washington, Oregon, and California. This action is intended primarily to maintain the traditional fishing season, prevent potential bycatches of rockfish and salmon south of 39° N. latitude from exceeding current levels, and spread the harvesting and processing of whiting along the entire

coast. This action is authorized under the Pacific Coast Groundfish Fishery Management Plan (FMP).

DATES: Comments on the proposed rule must be received on or before December 16, 1991.

ADDRESSES: Comments on the proposed rule should be sent to Mr. Rolland A. Schmitt, Director, Northwest Region, National Marine Fisheries Service, 7600 Sand Point Way NE., BIN C15700, Seattle, WA 98115-0070; or Mr. E. Charles Fullerton, Director Southwest Region, National Marine Fisheries Service, 300 S. Ferry Street, Terminal Island, CA 90731-7415.

Copies of the Environmental Assessment/Regulatory Impact Review (EA/RIR) are available from the Pacific Fishery Management Council, 2000 SW First Avenue, suite 420, Portland, Oregon 97201.

FOR FURTHER INFORMATION CONTACT:

William L. Robinson at 206-526-6140, Rodney R. McInnis at 213-514-6199, or the Pacific Fishery Management Council at 503-326-6352.

SUPPLEMENTARY INFORMATION: The Pacific Fishery Management Council (Council) makes recommendations to the Secretary of Commerce for the management of fisheries under the FMP. Procedures for establishing this season opening date are found at section III.B. of the appendix to 50 CFR part 663 (the socio-economic framework) and were added under Amendment 4 to the FMP. An analysis of the biological, social, and economic impacts is contained in the EA/RIR which is available from the Council at the address above.

Background

Until 1991, domestic shore-based processors used less than 5 percent of the annual quota for Pacific whiting (whiting); the remaining 95 percent was taken either by joint ventures (U.S.-caught/foreign-processed at-sea) or by foreign directed fisheries (foreign caught and processed). Foreign vessels were not allowed to operate south of 39° N. latitude (near Point Arena, California). Whiting migrate from south to north until the late summer, and usually are distributed along the coast (north of 39° N. latitude) by late April or May. The directed foreign fishery was restricted to a June 1 opening. The joint venture fishery had no season restriction, but, since foreign vessels could not operate south of 39° N. latitude, and whiting generally are not available in large concentrations north of 39° N. latitude until April or May, the joint venture fishery usually started slowly in April and was in full force by May or June.

Shore-based processors of whiting are all located north of 39° N. latitude, and since the vessels delivering to them prefer to fish relatively close to the plant to maintain product quality, shore-based operations generally started slowly in March and reached full production in April or May. Thus, the traditional domestic whiting season did not begin until the April-May period.

In 1991, domestic processors (shore-based plants and at-sea processing vessels) are expected to use the entire whiting quota, displacing foreign at-sea processors. Because the domestic at-sea processing fleet is not restricted by either the June 1 season that applied to the directed foreign fishery for whiting, or by the prohibition against operating south of 39° N. latitude that applied to all foreign processing vessels, the domestic fleet is able to fish both earlier and farther south than previous foreign and joint venture fisheries.

The 1991 domestic fishery for whiting started in mid-March, with harvests reaching 25,000 metric tons (mt) per week by May. This high catch rate was due overwhelmingly to the at-sea processing fleet; shore-based processors are expected to process less than 31,000 mt for all of 1991. About 43,500 mt of whiting (20 percent of the 228,000 mt coastwide quota) were taken in the Monterey area (between 40°30' N. latitude and 36°00' N. latitude), an area that was lightly exploited in the past due to the prohibition against foreign vessels processing south of 39° N. latitude. The salmon bycatch rate was low in the Monterey area (0.008 salmon per metric ton of whiting); however, this is the area where Sacramento winter-run chinook salmon, listed as a threatened species under the Endangered Species Act, are most likely to be intercepted, especially inshore from January through March.

The catch in the Monterey area included 790 mt of rockfish, of which 478 mt were chilipepper and 12 mt were bocaccio. Intensified or earlier fishing effort could increase the bycatch of these as well as other rockfish species, particularly those that experience wide fluctuations in recruitment like bocaccio. The Council is concerned that significant amounts of fishing earlier in the year would: (1) Increase the potential for higher catches of chilipepper and bocaccio rockfish and of salmon, particularly Sacramento winter-run chinook; and (2) increase the possibility that the high-capacity at-sea processing vessels could preempt processing opportunities for shore-based processors along the entire coast.

To address these potential problems, the Council initially considered several opening dates, including January 1

(status quo), April 1, April 15, May 1, a date later than May 1, and a framework that would allow timely adjustment (within specified limits) from year to year. These alternatives were examined in the EA/RIR, specifically with respect to impacts on the bycatch of rockfish and salmon, yield per recruit and sustainable yield, product quality, the geographic distribution of the catch, and on potential allocations to different industry segments.

In making its recommendation for a preferred alternative at its September 1991 meeting, the Council sought to keep the bycatch of rockfish and salmon from increasing over current levels and to spread the harvest and processing of whiting along the coast so that, like the traditional whiting fishery, it is not concentrated in any particular area. The Council also sought to enhance product quality, yield per recruit, and sustainable yield.

The Council considered public comment on several alternative opening dates at both its July and September 1991 meetings, and reviewed the EA/RIR and advice from its advisory subpanels before making a preliminary recommendation for an April 15 opening date. In addition to its preferred alternative of April 15, the Council will continue to solicit public comment, both before and during its November meeting, on the alternative opening dates of April 1 and May 1. Based on public comment and further analysis, the Council will make its final recommendation at its November meeting. Consequently, NOAA is seeking public comment on the Council's preferred alternative of April 15 as well as the other alternatives of January 1 (status quo), April 1, and May 1. The Council has decided not to pursue an option for a summer or fall opening.

An opening either in April or May appears to achieve the objectives of maintaining traditional harvesting and processing patterns along the coast, and of keeping the bycatch of salmon and rockfish from exceeding current levels. An opening in April or May also would occur after the winter spawning season, and could improve yield and product quality relative to a January opening. An additional benefit of a later opening date potentially would be to provide a longer operating season for shore-based processors. For example, a May 1 opening would provide about 3 weeks of fishing for whiting before most at-sea processors depart for the June 1 pollock opening in Alaska (compared with 6 weeks in 1991). However, this action does not prevent at-sea processors from remaining in the whiting fishery, or from returning after the end of the pollock season if whiting are available.

Classification

This proposed rule is published under authority of section 305(d) of the Magnuson Act, 16 U.S.C. 1855(d), and was prepared at the request of the Council. The Assistant Administrator for Fisheries, NOAA (Assistant Administrator), has determined that this proposed rule is necessary for the conservation and management of the Pacific coast groundfish fishery and that it is consistent with the Magnuson Act and other applicable law. The Assistant Administrator, before publishing a final rule, will take into account the data and comments received during the comment period and during subsequent Council meetings.

The Council prepared an environmental assessment (EA) for this proposed rule, and concluded that there will be no significant environmental impact on the environment. You may obtain a copy of the EA from the Council (see ADDRESSES).

NMFS issued a Biological Opinion under the Endangered Species Act (ESA) on August 10, 1990, pertaining to Amendment 4 of the FMP. It concluded that implementation of the FMP would not jeopardize the continued existence of any of the species considered. Consultation was reinitiated on this action at the request of the Council because of substantial changes the structure of the whiting fishery and renewed concern about salmon bycatch and the resulting effect on Sacramento winter-run chinook salmon. Approval of the final biological opinion is expected in November.

The Assistant Administrator has determined that this is not a major rule requiring a regulatory impact analysis under Executive Order 12291. The proposed action will not have a cumulative effect on the economy of \$100 million or more nor will it result in a major increase in costs to consumers, industries, government agencies, or geographical regions. No significant adverse impacts are anticipated on competition, employment, investments, productivity, innovation, or competitiveness of U.S.-based enterprises. This conclusion is based on the EA/RIR prepared for this rule which indicates that the gross revenues generated from the whiting fishery are not expected to differ substantially as a result of setting an opening date in April or May (when the traditional domestic whiting season started). The net effect of this rule will be to distribute the impact of the fishery along the coast; it does guarantee shares to any particular user group.

The General Counsel of the Department of Commerce certified to the Small Business Administration that this proposed rule, if adopted, will not have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act, 5 U.S.C. 603 *et seq.* This rule would spread the impact of the fishery along the coast without encouraging additional effort early in the year in areas that traditionally have been unexploited by the whiting fleet south of 39° N. latitude. As a result, approximately 15 shore-based processors north of 39° N. latitude, who rely predominantly on local concentrations of whiting, will not be precluded by an early fishery in southern waters. (Large at-sea processors are not considered small businesses based on MNFS survey information indicating average annual gross revenues in the range of \$8,000,000.) Consequently, the Assistant Administrator initially determined that this proposed action would not have a significant impact on a substantial number of small entities and, therefore,

a regulatory flexibility analysis for this action was not prepared.

This proposed rule does not contain a collection-of-information requirement for purposes of the Paperwork Reduction Act, 44 U.S.C. 3510 *et seq.*

The Council has initially determined that this proposed rule is consistent to the maximum extent practicable with the applicable State coastal zone management programs as required. This initial determination has been submitted for review by the responsible State agencies under section 307 of the Coastal Zone Management Act.

This rule does not contain policies with federalism implications sufficient to warrant preparation of a federalism assessment under Executive order 12612.

List of Subjects in 50 CFR Part 663

Administrative practice and procedure, Fisheries, Fishing, Reporting and recordkeeping requirements.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: November 20, 1991.

Samuel W. McKeen,

Acting Assistant Administrator for Fisheries,
National Maine Fisheries Service.

For the reasons set forth in the preamble, 50 CFR part 663 is proposed to be amended as follows:

PART 663—PACIFIC COAST GROUND FISH FISHERY

1. The authority citation for part 663 continues to read as follows:

Authority: 16 U.S.C. 1801 *et seq.*

2. In section 663.23, paragraph (b)(3), which expires on December 31, 1991, is replaced with a new paragraph (b)(3), as follows:

§ 663.23 Catch restrictions.

* * * * *

(b) * * *

(3) *Pacific whiting—Season.* Pacific whiting may not be taken and retained, possessed, or landed in any calendar year between 0001 hours, local time, January 1 through 2400 hours, local time, April 14.

* * * * *

[FR Doc. 91-28285 Filed 11-20-91; 4:17 pm]

BILLING CODE 3510-22-M

Notices

Federal Register

Vol. 56, No. 227

Monday, November 25, 1991

This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

ARMS CONTROL AND DISARMAMENT AGENCY

Performance Review Board; Membership

AGENCY: Arms Control and Disarmament Agency.

ACTION: Notice of membership of Performance Review Board.

SUMMARY: In accordance with 5 U.S.C. 4314(c)(4), the U.S. Arms Control and Disarmament Agency announces the appointment of Performance Review Board members.

EFFECTIVE DATE: January 1, 1992.

FOR FURTHER INFORMATION CONTACT: Nancy Aderholdt, Director of Personnel, U.S. Arms Control and Disarmament Agency, Washington, DC 20451 (202) 647-2034.

The following are the names and present titles of the individuals appointed to the register from which Performance Review Boards will be established by the U.S. Arms Control and Disarmament Agency during the period beginning on the effective date of this notice and ending when a new register is published in approximately one year. Specific Performance Review Boards will be established as needed from this register.

These appointments supersede those in the announcement published at 55 FR 53172 on December 7, 1990.

Name	Title
Stephen Read Hanmer Jr.	Deputy Director
Mariner G. Cox	Executive Assistant
Manfred Eimer	Assistant Director, Verification and Implementation Bureau
Edward Lacey	Deputy Assistant Director, Verification and Implementation Bureau

Name	Title
O. James Sheaks	Chief, Verification Division, Verification and Implementation Bureau
Bradley Gordon	Assistant Director, Nonproliferation Policy Bureau
Norman Wulf	Principal Deputy Assistant Director, Nonproliferation Policy Bureau
Vincent DeCain	Deputy Assistant Director, Nonproliferation Policy Bureau
Robert Rochlin	Chief Scientist, Nonproliferation Policy Bureau
Michael Rosenthal	Chief, International Nuclear Affairs Division, Nonproliferation Policy Bureau
Robert Summers	Chief, Defense Programs and Analysis Division, Nonproliferation Policy Bureau
Michael Moodie	Assistant Director, Multilateral Affairs Bureau
David Clinard	Principal Deputy Assistant Director, Multilateral Affairs Bureau
Donald Mahley	Deputy Assistant Director, Multilateral Affairs Bureau
Susan Koch	Assistant Director, Strategic and Nuclear Affairs Bureau
R. Lucas Fischer	Deputy Assistant Director, Strategic and Nuclear Affairs Bureau
Stanley Riveles	Chief, Strategic Affairs Division, Strategic and Nuclear Affairs Bureau
Karin Look	Chief, Theater Affairs Division, Strategic and Nuclear Affairs Bureau
David Wollan	Chief, Defense and Space Division, Strategic and Nuclear Affairs Bureau
William J. Montgomery	Administrative Director
Thomas Graham, Jr.	General Counsel
Mary Elizabeth Hoinkes	Deputy General Counsel
Norman Clyne	Special Assistant to the General Counsel
Richard Holwill	Director of Congressional Affairs
Joerg Menzel	Principal Deputy of the On-Site Inspection Agency
Barry Daniel	Director of Public Affairs
Alfred Lieberman	Chief, Operations Analysis Group
Michele Markoff	Senior Policy Advisor

William J. Montgomery,

Administrative Director.

[FR Doc. 91-28200 Filed 11-22-91; 8:45 am]

BILLING CODE 6820-32-M

DEPARTMENT OF COMMERCE

National Institute of Standards and Technology

[Docket No. 910935-1235]

RIN 0693-AA78

Proposed Interpretation No. 1, Invalid Arguments in Intrinsic Functions, for Federal Information Processing Standard (FIPS) 21-3, COBOL; Request for Comments

AGENCY: National Institute of Standards and Technology (NIST), Commerce.

ACTION: Notice; request for comments.

SUMMARY: Interpretation No. 1 pertaining to the handling of invalid arguments in intrinsic functions for FIPS 21-3, COBOL, is being proposed for Federal use.

This proposed interpretation was developed in accordance with Interpretation Procedures for Federal Information Processing Standards for Software, Federal Information Processing Standard Publication 29-2, dated September 14, 1987. The proposed interpretation, if adopted, will serve as additional specifications to FIPS 21-3 which adopts voluntary industry standards, ANSI X3.23-1985 and ANSI X3.23-A-1989.

The proposed interpretation contains the definition of the problem, discussion of the issues, the interpretation, the determination that no clarification to FIPS 21-3 is needed to effect the interpretation, and the effective date of the interpretation.

Prior to approval of the proposed interpretation by the National Institute of Standards and Technology, it is essential to assure that proper consideration is given to the needs and views of manufacturers, the public, and State and local governments. The purpose of this notice is to solicit such views.

DATES: Comments on this proposed interpretation for FIPS 21-3 must be received by February 24, 1992. Copies of FIPS 21-3 are available from the National Technical Information Service

(NTIS), U.S. Department of Commerce, Springfield, VA 22161.

ADDRESSES: Written comments concerning the proposed interpretation should be sent to: Director, Computer Systems Laboratory, Attn: COBOL Interpretations, Technology Building, Room B154, National Institute of Standards and Technology, Gaithersburg, MD 20899.

Written comments received in response to this notice will be made part of the public record and will be made available for inspection and copying in the Central Reference and Records Inspection Facility, room 6020, Herbert C. Hoover Building, 14th Street between Pennsylvania and Constitution Avenues, NW., Washington, DC 20230.

FOR FURTHER INFORMATION CONTACT: Ms. Judy Kailey, National Institute of Standards and Technology, Gaithersburg, MD 20899 (301) 975-3259.

Authority: Federal Information Processing Standards Publications (FIPS PUBS) are issued by the National Institute of Standards and Technology after approval by the Secretary of Commerce pursuant to section III(d) of the Federal Property and Administrative Services Act of 1949 as amended by the Computer Security Act of 1987, Public Law 100-235.

Dated: November 18, 1991.

John W. Lyons,
Director.

Proposed Interpretation No. 1, Invalid Arguments in Intrinsic Functions, for FIPS 21-3 COBOL

Definition of the Problem: The following questions have been raised concerning invalid arguments being specified in intrinsic functions:

1. If it is syntactically detectable at compile time that a given intrinsic function argument violates a specified constraint rule for the function argument, must FIPS conforming compilers nevertheless process the specified intrinsic function as conforming source code?
2. If an intrinsic function argument references a data item whose data is the correct class and category (and all other argument constraints for the function are correct) but the data item referenced by the argument contains invalid data, is it considered a constraint violation or an incompatible data violation in FIPS COBOL?
3. If, at run-time, an intrinsic function argument violates an argument constraint specified in the standard (a violation of range or permissible value rather than a violation of class or category), does the phrase "the returned value for the function is undefined" mean that:

- a. The behavior of the program from that statement on is undefined; or
 - b. The value returned from the function is undefined, but the program must continue to execute in accordance with the COBOL rules for transfer of control; or
 - c. There is some other meaning concerning program execution continuation and transfer of control?
4. If the answer to the previous question is that the program must continue to execute after evaluation of a function whose argument violates argument constraints, does it mean that although the value returned is undefined the value must be consistent with the function type?

Discussion of the Issues:

References:

1. ANSI X3.23-1985, page I-9, paragraph 1.6.
2. ANSI X3.23-1985, page I-9, paragraph 1.7.
3. ANSI X3.23-1985, page III-23, definition of Source Program.
4. ANSI X3.23-1985, page IV-25, paragraph 4.4.
5. ANSI X3.23-1985, page VI-70, paragraph 6.4.7.
6. ANSI X3.23a-1989, page A-24, entry for page XVII-98.
7. ANSI X3.23a-1989, page A-27, paragraph 1.2.2.

Reference 3 states that in X3.23-1985 the term source program "always refers to a syntactically correct set of COBOL statements." The first sentence of reference 1 states, "A conforming source program is one which does not violate the explicitly stated provisions and specifications of Standard COBOL." Thus, whether or not a violation of an explicitly stated argument constraint is detectable at compile time, if such a violation exists in a source program that program does not conform to Standard COBOL.

The third paragraph of reference 1 above states, "There are, in Standard COBOL, situations in which the results of executing a statement are undefined or unpredictable (see XVII-96, Undefined Language Element List). A COBOL source program which allows this to happen may nevertheless be a conforming program, although the resultant execution is not defined by Standard COBOL."

The last sentence of reference 7 above states, "If, at the time a function is referenced, the arguments specified for that reference do not have values that comply with the specified constraints, the returned value for the function is undefined." Reference 6 above placed this sentence on the Undefined

Language Element List. Thus, according to reference 1 cited above, if a program allows a reference to a function whose argument does not have a value that complies with the constraints specified for that argument, the resultant execution of that program is not defined in Standard COBOL.

Reference 2 above elaborates further on this position by stating that, "The translation of a conforming source program by a conforming implementation and the subsequent execution of the resultant object program is defined only to the extent specified in Standard COBOL. However, the preceding statement does not imply that the program will be translated or executed successfully; translation and execution depends on other factors, such as . . . the data upon which the program operates." Therefore, even if the program that allows a reference to a function whose argument does not have a value that complies with the constraints specified for that argument is determined to be a conforming source program, the subsequent execution of the resultant object program still is not defined in Standard COBOL (reference 1, third paragraph).

Proposed Interpretation: The proposed interpretation is that any time in a source program an intrinsic function argument constraint specification is violated, the returned value for the function is undefined and the resultant execution of that program also is undefined. This interpretation applies whether or not the argument constraint violation is detectable at compile time.

Specific responses to each of the questions stated in the Definition of the Problem above are as follows:

Question 1. A source program that is not a syntactically correct set of COBOL statements (reference 3) is not a conforming COBOL source program (reference 1). The translation of a nonconforming source program by a conforming implementation is not addressed and therefore is undefined in Standard COBOL.

Question 2. If the content of a data item referenced as an intrinsic function argument does not conform to the implicitly or explicitly specified attributes of that data item (reference 4), the stated provisions of Standard COBOL have been violated. If such a violation exists in a source program, the resultant execution of that program is undefined in Standard COBOL (reference 1). Whether such a violation is categorized as an argument constraint violation or an invalid data violation (reference 5), the results of executing a

program containing such a violation is undefined in Standard COBOL.

Question 3. If, at the time of reference, the value of a data item referenced as an intrinsic function argument does not comply with the specified constraints for that argument, the returned value for the function is undefined (reference 7), and therefore, the resultant execution of the program is undefined (references 1 and 2). The continued execution of the program in accordance with the rules for transfer of control (reference 5) is likewise undefined.

Question 4. This question is irrelevant since continued execution of the program is undefined. See the response to question 3.

Clarification of FIPS 21-3, COBOL.

None.
Effective Date of Interpretation. The effective date of this interpretation shall be 30 days after the date the approved interpretation is published in the Federal Register.

[FR Doc. 91-28197 Filed 11-22-91; 8:45 am]

BILLING CODE 3510-CN-M

[Docket No. 910936-1236

RIN 0693-AA95

Proposed Federal Information Processing Standard (FIPS) for VHSIC Hardware Description Language (VHDL); Request for Comments

AGENCY: National Institute of Standards and Technology (NIST), Commerce.

ACTION: Notice; Request for comments.

SUMMARY: This proposed Federal Information Processing Standard (FIPS) will adopt the standard hardware description language of the ANSI/IEEE 1076-1987, IEEE Standard VHDL Language Reference Manual. This proposed standard is for use by computing professionals involved in high level digital hardware specification, development and implementation.

Prior to the submission of this proposed FIPS to the Secretary of Commerce for review and approval, it is essential to assure that consideration is given to the needs and views of manufacturers, the public, and state and local governments. The purpose of this notice is to solicit such views.

This proposed FIPS contains two sections: (1) An announcement section, which provides information concerning the applicability, implementation, and maintenance of the standard; and (2) a specifications section which deals with the technical requirements of the

standard. Only the announcement section of the standard is provided in this notice. Interested parties may obtain copies of the technical specifications (ANSI/IEEE 1076-1987) from the IEEE Service Center, 445 Hoes Lane, P.O. Box 1331, Piscataway, NJ 08855-1331, telephone 1-800-678-4333.

DATES: Comments on this proposed FIPS must be received on or before February 24, 1992.

ADDRESS: Written comments concerning the proposed FIPS should be sent to: Director, Computer Systems Laboratory, ATTN: Proposed FIPS for VHDL, Technology Building, room B-154, National Institute of Standards and Technology, Gaithersburg, MD 20899.

Written comments received in response to this notice will be made part of the public record and will be made available for inspection and copying in the Central Reference and Records Inspection Facility, room 6020, Herbert C. Hoover Building, 14th Street between Pennsylvania and Constitution Avenues, NW., Washington, DC 20230.

FOR FURTHER INFORMATION CONTACT: Dr. William H. Dashiell, National Institute of Standards and Technology, Gaithersburg, MD 20899, (301) 975-2490. Dated: November 18, 1991.

John W. Lyons,
Director.

Federal Information Processing Standards Publication _____,

(Date)

Announcing the Standard for VHSIC Hardware Description Language (VHDL)

Federal Information Processing Standards Publications (FIPS PUBS) are issued by the National Institute of Standards and Technology after approval by the Secretary of Commerce pursuant to Section 111(d) of the Federal Property and Administrative Services Act of 1949 as amended by the Computer Security Act of 1987, Public Law 100-235.

1. *Name of Standard.* VHSIC Hardware Description Language (VHDL) (FIPS PUB _____).

2. *Category of Standard.* Software Standard, Hardware Description Language.

3. *Explanation.* This publication announces the adoption of the Federal Information Processing Standard (FIPS) for VHDL. This FIPS adopts American National Standard Hardware Description Language VHDL (ANSI/IEEE 1076-1987) as stipulated in the Specifications Section. The American National Standard specifies the form and establishes the interpretation of programs expressed in VHDL. The

purpose of the standard is to promote portability of VHDL programs for use on a variety of data processing systems. The standard is used by implementors as the reference authority in developing compilers, interpreters, analyzers, simulators or other forms of high level language processors, and is used by digital hardware designers, and by other computer professionals who need to know the precise syntactic and semantic rules of the standard and who need to provide specifications for digital hardware descriptions.

4. *Approving Authority.* Secretary of Commerce.

5. *Maintenance Agency.* U.S. Department of Commerce, National Institute of Standards and Technology (NIST).

6. *Cross Index.* ANSI/IEEE 1067-1987, IEEE Standard VHDL Language Reference Manual.

7. *Related Documents.*

a. Federal Information Resources Management Regulation (FIRMR) 201-3.1, Operations and Control—Standards, and 201-39, Acquisition of Information Processing Resources by Contracting.

b. Federal Information Processing Standards Publication 29-2, Interpretation Procedures for Federal Information Processing Standards for Software.

8. *Objectives.* Federal standards for high level digital design information and documentation languages that permit Federal departments and agencies to exercise more effective control over the design, production, management, and maintenance of digital electronic systems. The primary objectives of this Federal hardware description language standard are:

- To encourage more effective utilization of design personnel by ensuring that design skills acquired under one job are transportable to other jobs, thereby reducing the cost of programmer retraining;
- To reduce the cost of design by achieving increased designer productivity and design accuracy through the use of formal languages;
- To reduce the overall life cycle cost for digital systems by establishing a common documentation language for the transfer of digital design information across organizational boundaries;
- To protect the immense investment of digital hardware from obsolescence by insuring to the maximal feasible extent that Federal hardware description language standards are technically sound and that subsequent revisions are compatible with the installed base.

- To reduce Federal inventory of electronic digital replacement parts.
- To increase the sources of supplies which can satisfy government requirements for mission specific electronic digital components.

Government-wide attainment of the above objectives depends upon the widespread availability and use of comprehensive and precise standard language specifications.

9. Applicability.

a. Federal standards for hardware description languages are applicable for the design and documentation of digital systems developed for government use. This standard is suitable for use in the following digital system applications:

- Primary design and documentation of digital systems, subsystems, assemblies, hybrid components, and components;
- Formal specifications of digital systems throughout the procurement, contracting and development process;
- Test generation for digital systems, subsystems, assemblies, hybrid components, and components;
- Re-procurement and redesign of digital systems, subsystems, assemblies, hybrid components, and components.

b. The use of FIPS hardware description languages applies when one or more of the following situations exist:

- The digital system will need to be maintained and upgraded.
- The digital system is under constant revision during the development process.
- It is desired to have the design understood by multiple people, groups, or organizations.
- The system under development is to be designed by multiple people, groups, or organizations.
- Accurate unambiguous specifications are required in the bid and contracting process.

10. *Specifications.* The specifications for this standard are the language specifications contained in ANSI/IEEE 1076-1987, IEEE Standard VHDL Language Reference Manual.

This FIPS does not allow conforming implementations to extend the language. A conforming implementation is one that does not allow inclusion of substitute or additional language elements in order to accomplish a feature of the language as specified in the language standard. A conforming implementation is one which adheres to and implements all of the language specifications contained in ANSI/IEEE 1076-1987 except where the language standard permits deviations and which specifies conspicuously in a separate

section in the conforming implementation documentation all such permitted variations. Also, such conformance shall be with default language processor system option settings.

The ANSI/IEEE 1076-987 document does not specify limits on the size or complexity of programs, the results when the rules of the standard fail to establish an interpretation, the means of supervisory control programs, or the means of transforming programs for processing.

11. *Implementation.* The implementation of this standard involves three areas of consideration: acquisition of VHDL processors, interpretation of FIPS VHDL, and validation of VHDL processors.

11.1 *Acquisition of VHDL Processors.* This publication is effective (six months after date of publication of final document in the *Federal Register*). VHDL processors acquired for Federal use after this date should implement FIPS VHDL. Conformance to this standard is applicable whether VHDL processors are developed internally, acquired as part of an ADP system procurement, acquired by separate procurement, used under an ADP leasing management, or specified for use in contracts for hardware description services.

A transition period provides time for industry to produce VHDL processors conforming to the standard. The transition period begins on the effective date and continues for twelve (12) months thereafter. The provisions of this publication apply to orders placed after the effective date of this publication; however, a VHDL processor conforming to FIPS VHDL, if available, may be acquired for use prior to the effective date. If a conforming VHDL processor is not available, a VHDL processor not conforming to this standard may be acquired for interim use during the transition period.

11.2 *Interpretation of FIPS VHDL.* The National Institute of Standards and Technology provides for the resolution of questions regarding the specifications and requirements, and issues official interpretations as needed. All questions about the interpretation of this standard should be addressed to: Director, Computer Systems Laboratory, ATTN: FIPS VHDL Interpretation, National Institute of Standards and Technology, Gaithersburg, MD 20899, Telephone: (301) 975-2490.

11.3 *Validation of VHDL Processors.* The validation of VHDL processors for conformance to this standard applies when NIST VHDL validation procedures are available. At the present time NIST

does not have procedures for validating VHDL processors. NIST is currently investigating methods which may be considered for validating processors for conformance to this standard.

For further information contact: Director, Computer Systems Laboratory, ATTN: FIPS VHDL Validation, National Institute of Standards and Technology, Gaithersburg, MD 20899, (301) 975-2490.

12. Waivers.

Under certain exceptional circumstances, the heads of Federal departments and agencies may approve waivers to Federal Information Processing Standards (FIPS). The head of such agency may redelegate such authority only to a senior official designated pursuant to section 3506(b) of title 44, U.S. Code. Waivers shall be granted only when:

a. Compliance with a standard would adversely affect the accomplishment of the mission of an operator of a Federal computer system, or

b. Cause a major adverse financial impact on the operator which is not offset by Government wide savings.

Agency heads may act upon a written waiver request containing the information detailed above. Agency heads may also act without a written waiver request when they determine that conditions for meeting the standard cannot be met. Agency heads may approve waivers only by a written decision which explains the basis on which the agency head made the required finding(s). A copy of each such decision, with procurement sensitive classified portions clearly identified, shall be sent to: National Institute of Standards and Technology, ATTN: FIPS Waiver Decisions, Technology Building, Room B-154, Gaithersburg, MD 20899.

In addition, notice of each waiver granted and each delegation of authority to approve waivers shall be sent promptly to the Committee on Government Operations of the House of Representatives and the Committee on Governmental Affairs of the Senate and shall be published promptly in the *Federal Register*.

When the determination on a waiver applies to the procurement of equipment and/or services, a notice of the waiver determination must be published in the *Commerce Business Daily* as a part of the notice of solicitation for offers of an acquisition or, if the waiver determination is made after that notice is published, by amendment to such notice.

A copy of the waiver, any supporting documents, the document approving the waiver and any supporting and accompanying documents, with such

deletions as the agency is authorized and decides to make under 5 U.S.C. 552(b), shall be part of the procurement documentation and retained by the agency.

13. *Where to Obtain Copies.* Copies of this publication are for sale by the National Technical Information Service, U.S. Department of Commerce, Springfield, VA 22161. (Sale of the included specifications document is by arrangement with The Institute of Electrical and Electronics Engineers, Inc.) When ordering, refer to Federal Information Processing Standards Publication _____ (FIPSPUB _____), and title. Payment may be made by check, money order, or deposit account.

[FR Doc. 91-28198 Filed 11-22-91; 8:45 am]

BILLING CODE 3510-CN-M

COMMODITY FUTURES TRADING COMMISSION

Coffee, Sugar & Cocoa Exchange, Inc. Proposed Contract

AGENCY: Commodity Futures Trading Commission.

ACTION: Notice of availability of the terms and conditions of proposed commodity futures contract.

SUMMARY: The Coffee, Sugar & Cocoa Exchange, Inc. (CSCE or Exchange) has applied for designation as a contract market in Brazil differential coffee futures. The Director of the Division of Economic Analysis (Division) of the Commission, acting pursuant to the authority delegated by Commission Regulation 140.96, has determined that publication of the proposal for comment is in the public interest, will assist the Commission in considering the views of interested persons, and is consistent with the purposes of the Commodity Exchange Act.

DATES: Comments must be received on or before December 26, 1991.

ADDRESSES: Interested persons should submit their views and comments to Jean A. Webb, Secretary, Commodity Futures Trading Commission, 2033 K Street NW., Washington, DC 20581. Reference should be made to the Brazil differential futures contract.

FOR FURTHER INFORMATION CONTACT: Please contact Fred Linse of the Division of Economic Analysis, Commodity Futures Trading Commission, 2033 K Street NW., Washington, DC 20581, telephone 202-254-7303.

SUPPLEMENTARY INFORMATION: The proposed contract will be priced as a differential to the existing Coffee "C" contract rather than as an absolute price

of coffee. The proposed contract calls for the delivery of Brazilian coffee which meets specified standards in Exchange-licensed warehouses in the ports of New York, New Orleans, San Francisco, Houston, Jacksonville and Norfolk.

Copies of the terms and conditions of the proposed contract will be available for inspection at the Office of the Secretariat, Commodity Futures Trading Commission, 2033 K Street, NW., Washington, DC 20581. Copies of the terms and conditions can be obtained through the Office of the Secretariat by mail at the above address or by phone at (202) 254-6314.

Other materials submitted by the CSCE in support of the application for contract market designation may be available upon request pursuant to the Freedom of Information Act (5 U.S.C. 552) and the Commission's regulations thereunder (17 CFR part 145 (1987)), except to the extent they are entitled to confidential treatment as set forth in 17 CFR part 145 and 145.9. Requests for copies of such materials should be made to the FOI, Privacy and Sunshine Act Compliance Staff of the Office of the Secretariat at the Commission's headquarters in accordance with 17 CFR 145.7 and 145.8.

Any person interested in submitting written data, views, or arguments on the terms and conditions of the proposed contract, or with respect to other materials submitted by the CSCE in support of the application, should send such comments to Jean A. Webb, Secretary, Commodity Futures Trading Commission, 2033 K Street, NW., Washington, DC 20581 by the specified date.

Issued in Washington, DC, on November 19, 1991.

Gerald Gay,
Director.

[FR Doc. 91-28170 Filed 11-22-91; 8:45 am]

BILLING CODE 6351-01-M

DEPARTMENT OF DEFENSE

Office of the Secretary

Defense Intelligence Agency Advisory Board; Closed Meeting

AGENCY: Defense Intelligence Agency Advisory Board.

ACTION: Notice of closed meeting.

SUMMARY: Pursuant to the provisions of subsection (d) of section 10 of Public Law 92-463, as amended by section 5 of Public Law 94-409, notice is hereby given that a closed meeting of a panel of

the DIA Advisory Board has been scheduled as follows:

DATE: Monday, December 9, 1991 (9 a.m. to 5 p.m.).

ADDRESS: The DIAC, Bolling AFB, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Lieutenant Colonel John G. Sutay, USAF, Chief, DIA Advisory Board, Washington, DC 20340-1328 (202/373-4930).

SUPPLEMENTARY INFORMATION: The entire meeting will be devoted to the discussion of classified information as defined in section 552b(c)(1), title 5 of the U.S. Code and therefore will be closed to the public. Subject matter will be used in a special study on Advanced Air Defense.

Dated: November 19, 1991.

L.M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 91-28183 Filed 11-22-91; 8:45 am]

BILLING CODE 3810-01-M

Office of the Secretary of Defense

Strategic Defense Initiative Organization Notice of Intent (NOI) To Prepare an Environmental Impact Statement (EIS), for the Proposed Action to Launch Strategic Target System Boosters From the Kauai Test Facility on the Pacific Missile Range Facility, Barking Sands, Kauai, HI

SUMMARY: United States Army Strategic Defense Command (USASDC) is executing a program in support of the Strategic Defense Initiative Organization (SDIO). The proposed program would involve launching the Strategic Target System boosters from the Kauai Test Facility (KTF), located on the Pacific Missile Range Facility (PMRF), Kauai, Hawaii. The boosters would deliver target vehicles to the U.S. Army Kwajalein Atoll, Republic of the Marshall Islands, where existing sensors can collect data on the payloads. USASDC is the lead agency for preparing the Environmental Impact Statement (EIS). SDIO, the U.S. Navy, and the U.S. Department of Energy will act as cooperating agencies.

RELATED ENVIRONMENTAL

DOCUMENTATION: The Strategic Target System program activities for design, booster motor refurbishment and testing, fabrication/assembly/testing, construction, flight preparation, launch/flight/data collection, and data analysis are discussed in the "Strategic Target System (STARS) Environmental Assessment (USASDC, July 1990)".

Information on specific effects by hydrogen chloride on the Kauai environment and whether the release of freon from the second stage thrust vector control would threaten to violate the Hawaiian Ozone Protection Statute is discussed in the "Supplement to the Strategic Target System (STARS) Environmental Assessment (USASDC, July 1991)".

Information on the Strategic Target System activities at the U.S. Army Kwajalein Atoll (USAKA) is discussed in the Final Environmental Impact Statement "Proposed Actions at U.S. Army Kwajalein Atoll (USASDC, October 1989)".

PROPOSED ACTION: To launch Strategic Target System boosters from the KTF up to four times per year over a 10-year period. These launches would include flights to be targeted to the Broad Ocean Area near USAKA or north of USAKA. A safety zone, called a launch hazard area, will be established around the launch pad and along the flight path of the STARS vehicle. This zone will include a 10,000 foot ground hazard arc on federal and non-federal lands surrounding the launch pad and ocean areas offshore of the PMRF.

Alternatives to the Proposed Action which may be considered include alternative boosters launched from alternative sites. Possible boosters and sites include the following:

I. Alternative Launch Boosters

- a. Castor
- b. Minuteman II
- c. Pegasus
- d. Polaris A-3
- e. Poseidon

II. Alternative Launch Sites

- a. Barge
- b. Johnston Island
- c. Kwajalein Atoll
- d. Midway Island
- e. Vandenberg Air Force Base
- f. Wake Island
- g. White Sands Missile Range, New Mexico

III. No Action

SCOPING: Areas to be addressed in the EIS will include air quality, public health and safety, biological and cultural resources, hazardous materials and wastes, land use, and noise. The potential for socioeconomic impacts and cumulative effects for each of these areas will also be addressed. The comments and questions received during public information meetings held on the Island of Kauai in June, 1990, and June and July, 1991, and during the thirty-day comment periods for the Strategic Target System environmental

assessment and its supplement will be used to assist the USASDC in identifying potential impacts to the quality of the human environment.

Individuals or organizations may participate in the scoping process for the Strategic Target System by providing written comment to: D.R. Galien, U.S. Army Strategic Defense Command, Attn: CSSD-EN, P.O. Box 1500, Huntsville, AL 35807-3801.

Questions regarding this proposal may be directed to the USASDC Public Affairs Office at (205) 955-3058, collect. Comments should be received by December 26, 1991.

Dated: November 20, 1991.

L. M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 91-28237 Filed 11-22-91; 8:45 am]

BILLING CODE 3810-01-M

Department of the Navy

Privacy Act of 1974; Deletion of a Record System

AGENCY: Department of the Navy, DoD.
ACTION: Deletion of a Record System.

SUMMARY: The Department of the Navy proposes to delete one existing system of records to its inventory of record systems subject to the Privacy Act of 1974, as amended (5 U.S.C. § 552a).

DATES: The deletion will be effective November 25, 1991.

FOR FURTHER INFORMATION CONTACT: Mrs. Gwendolyn Aitken, Head, PA/FOIA Branch, Office of the Chief of Naval Operations (OP-09B30), Department of the Navy, The Pentagon, Washington, DC 20350-2000. Telephone (703) 614-2004.

SUPPLEMENTARY INFORMATION: The Department of the Navy record system notices for records systems subject to the Privacy Act of 1974, as amended, (5 U.S.C. 552a) were published in the Federal Register as follows:

- 51 FR 12908 Apr. 16, 1986
- 51 FR 18086 May 16, 1986 (DON Compilation changes follow)
- 51 FR 19884 Jun. 3, 1986
- 51 FR 30377 Aug. 26, 1986
- 51 FR 30393 Aug. 26, 1986
- 51 FR 45931 Dec. 23, 1986
- 52 FR 2147 Jan. 20, 1987
- 52 FR 2149 Jan. 20, 1987
- 52 FR 8500 Mar. 18, 1987
- 52 FR 15530 Apr. 29, 1987
- 52 FR 22671 Jun. 15, 1987
- 52 FR 45846 Dec. 2, 1987
- 53 FR 17240 May 16, 1988
- 53 FR 21512 Jun. 8, 1988
- 53 FR 25363 Jul. 6, 1988
- 53 FR 39499 Oct. 7, 1988
- 53 FR 41224 Oct. 20, 1988

- 54 FR 8322 Feb. 28, 1989
- 54 FR 14378 Apr. 11, 1989
- 54 FR 32682 Aug. 9, 1989
- 54 FR 40160 Sep. 29, 1989
- 54 FR 41495 Oct. 10, 1989
- 54 FR 43453 Oct. 25, 1989
- 54 FR 45781 Oct. 31, 1989
- 54 FR 48131 Nov. 21, 1989
- 54 FR 51784 Dec. 18, 1989
- 54 FR 52976 Dec. 26, 1989
- 55 FR 21910 May 30, 1990 (Navy Mailing Addresses)
- 55 FR 37930 Sep. 14, 1990
- 55 FR 42758 Oct. 23, 1990
- 55 FR 47508 Nov. 14, 1990
- 55 FR 48678 Nov. 21, 1990
- 55 FR 53167 Dec. 27, 1990
- 56 FR 424, Jan. 4, 1991
- 56 FR 12721, Mar. 27, 1991
- 56 FR 27503, Jun. 14, 1991
- 56 FR 28144, Jun. 19, 1991
- 56 FR 31394, Jul. 10, 1991 (DoD Updated Indexes)
- 56 FR 40877, Aug. 16, 1991
- 56 FR 46167, Sep. 10, 1991

Dated: November 19, 1991.

L.M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

N01610-1

System name:

Navy Personnel Evaluation System (51 FR 18117, May 16, 1986).

Reason:

System is now obsolete. These records are no longer being collected and maintained.

[FR Doc. 91-28184 Filed 11-22-91; 8:45 am]

BILLING CODE 3810-01-M

DEPARTMENT OF EDUCATION

National Assessment Governing Board; Candidates To Fill Vacancies

AGENCY: National Assessment Governing Board.

ACTION: Recommendations for candidates to fill board vacancies.

SUMMARY: The National Assessment Governing Board is seeking recommendations for candidates to fill upcoming vacancies in the Board's membership. The Nominations Committee of the National Assessment Governing Board is accepting nominations for individuals representing the following categories: testing and measurement expert, general public, curriculum specialist, twelfth grade teacher, and chief state school officer. There will be one vacancy in each category with the exception of the one for testing and measurement where two vacancies will exist. Anyone wishing to nominate a candidate or candidates

should submit a letter outlining the nominees' qualifications, along with a complete and current resume. The nomination period begins with the publication of this notice and closes December 20, 1991. Nominations should be mailed to Mr. Thomas Topuzes, National Assessment Governing Board, 1100 L Street, NW., suite 7322, Washington, DC 20005-4013, Attention: Daniel B. Taylor. Telephone inquiries should be made to (202) 357-6938.

BACKGROUND INFORMATION: The National Assessment Governing Board is established under section 406(i) of the General Education Provisions Act (GEPA) as amended by the section 3403 of the National Assessment of Educational Progress Improvement Act (NAEP Improvement Act), Title III-C of the Augustus F. Hawkins—Robert T. Stafford Elementary and Secondary School Improvement Amendments of 1988 (Pub. L. 100-297), (20 U.S.C. 1221e-1). The Board is established to formulate policy guidelines for the National Assessment of Educational Progress. It is responsible for developing specifications for test design and methodology, developing guidelines and standards for analysis plans, and reporting and disseminating results. The Board also has responsibility for selecting subject areas to be assessed, identifying achievement goals for each age and grade tested, and establishing standards and procedures for interstate, regional, and national comparisons.

Dated: November 19, 1991.

Diane Ravitch,

Assistant Secretary and Counselor to the Secretary.

[FR Doc. 91-28177 Filed 11-22-91; 8:45 am]

BILLING CODE 4000-01-M

[CFDA No. 84.999E]

The National Assessment of Educational Progress (NAEP) Program; Notice Inviting Applications for a New Award for Fiscal Year 1992

PURPOSE OF PROGRAM: To conduct the design, item development, field testing, and printing of final assessment booklets for the 1994 National Assessment of Educational Progress.

ELIGIBLE APPLICANTS: Public, private, for-profit, and non-profit institutions, agencies, and other qualified organizations or consortia of such institutions, agencies, and organizations.

DEADLINE FOR TRANSMITTAL OF APPLICATIONS: January 10, 1992.

APPLICATIONS AVAILABLE: November 26, 1991.

AVAILABLE FUNDS: In fiscal year 1992, \$3,500,000 is available. It is anticipated that in fiscal year 1993, \$8,500,000 will be available for a total of \$12,000,000 during the 22-month project period.

ESTIMATED NUMBER OF AWARDS: 1.

PROJECT PERIOD: Up to 22 months.

APPLICABLE REGULATIONS: (a) The Education Department General Administrative Regulations (EDGAR) 34 CFR parts 74, 75, 77, 81, 82, 85, 86; and (b) The regulations in 34 CFR part 98 (Students Rights in Research, Experimental Activities, and Testing).

SUPPLEMENTARY INFORMATION: The National Assessment of Educational Progress is authorized by section 406 of the General Education Provisions Act (20 U.S.C. 1221e-1), as amended by Public Law 100-297. This law provides for the establishment of the National Assessment Governing Board ("Board"). The law requires the Board to formulate the policy guidelines for the National Assessment and select the subject areas to be assessed. The Board has determined that the 1994 National Assessment of Educational Progress is to assess 9-, 13-, and 17-year-olds in grades 4, 8, and 12 in reading, mathematics, science, history, and geography.

This current competition is for a cooperative agreement to conduct the design, item development, field testing, and printing of final assessment booklets in preparation for the 1994 NAEP. It is anticipated that two new awards (one for design, item development, scoring, analysis, and reporting and one for sampling and data collection) will be made in fiscal year 1993 to conduct the actual 1994 and future NAEP assessments. The scope of these activities are dependent upon future legislation.

Selection Criteria

Under 34 CFR 75.210(c), the Secretary is authorized to distribute an additional 15 points among the selection criteria to bring the total possible points to a maximum of 100 points. For the purpose of this competition, the Secretary will distribute the additional points as follows:

Plan of Operation (34 CFR 75.210(b)(3)). Fifteen (15) additional points will be added for a possible total of 30 points for this criterion.

For Applications or Information Contact

Steve Gorman, U.S. Department of Education, 555 New Jersey Avenue, NW., room 308b, Washington, DC 20208-5653. Telephone: (202) 219-1761. Deaf and hearing impaired individuals may call: The Federal Dual Party Relay

Service at 1-800-877-8339 (in the Washington, DC 202 area code, telephone 708-9300) between 8 a.m. and 7 p.m., Eastern time.

Program Authority: 20 U.S.C. 1221e-1.

Dated: November 21, 1991.

Diane Ravitch,

Assistant Secretary for Educational Research and Improvement.

[FR Doc. 91-28366 Filed 11-22-91; 8:45 am]

BILLING CODE 4000-01-M

[CFDA No.: 84.133D]

National Institute on Disability and Rehabilitation Research; Notice Inviting Applications for a New Award for a Program in Support of the Implementation of the Americans With Disabilities Act for Fiscal Year 1992

PURPOSE OF PROGRAM: The purpose of this program is to develop and disseminate information that will facilitate the implementation of the Americans With Disabilities Act (ADA). The National Institute on Disability and Rehabilitation Research (NIDRR) is requesting applications for a Materials Development Project in the area of Accessibility in Communications.

The final priority for this competition was published in the *Federal Register* on August 13, 1991 at 56 FR 40168. NIDRR published an application notice for this priority in FY '91, but did not receive any applications that were suitable for funding. Because of the importance of this priority area in facilitating implementation of the Americans With Disabilities Act, NIDRR is again accepting applications in this area. Potential applicants should respond on the basis of the final priority and should also note the supplementary selection criteria that are contained in the notice of final priorities. Additional selection criteria were published in the *Federal Register* on August 13, 1991 at 56 FR 40168.

ELIGIBLE APPLICANTS: Public and private agencies and organizations, including institutions of higher education, Indian tribes and tribal organizations, and for-profit and nonprofit entities may apply for awards under this program.

DEADLINE FOR TRANSMITTAL OF APPLICATIONS: January 31, 1992.

APPLICATIONS AVAILABLE: December 2, 1991.

AVAILABLE FUNDS: \$250,000.

ESTIMATED NUMBER OF AWARDS: 1.

Note: The estimates of funding levels and awards in this notice do not bind the Department of Education to a specific level of funding or number of grants, unless the

amount is otherwise specified by statute or regulation.

PROJECT PERIOD: Up to 24 months.

APPLICABLE REGULATIONS: The Education Department General Administrative Regulations (EDGAR), 34 CFR parts 74, 75, 77, 80, 81, 82, 85, and 86 and the regulations for this program in 34 CFR parts 350 and 355. Additional selection criteria were published in the *Federal Register* on August 13, 1991 at 56 FR 40168.

FOR FURTHER INFORMATION CONTACT: Yvonne Fleming, National Institute on Disability and Rehabilitation Research, U.S. Department of Education, 400 Maryland Avenue, SW., Washington, DC 20202. Telephone: (202) 732-1141. Deaf or hearing-impaired individuals may call (202) 732-5079 for TDD services.

FOR APPLICATIONS CONTACT: U.S. Department of Education, 400 Maryland Avenue, SW., Washington, DC 20202. Telephone: (202) 732-1141.

Program Authority: 29 U.S.C. 760-762.

Dated: November 20, 1991.

Robert R. Davila,

Assistant Secretary, Office of Special Education and Rehabilitative Services.

[FR Doc. 91-28242 Filed 11-22-91; 8:45 am]

BILLING CODE 4000-01-M

[CFDA NO.: 84.129V]

State Vocational Rehabilitation Unit In-Service Training; Notice Inviting Applications for New Awards for Fiscal Year (FY) 1992

Purpose of Program: To provide grants for in-service training to State vocational rehabilitation unit personnel in areas essential to effective management or in skill areas to improve the provision of vocational rehabilitation services.

Eligible Applicants: State agencies and other public or nonprofit agencies and organizations, including institutions of higher education, are eligible for assistance under this program.

Deadline for Transmittal of Applications: March 9, 1992.

Deadline for Intergovernmental Review: May 8, 1992.

Applications Available: January 8, 1992.

Available Funds: \$1,778,065.

Funds are available under this program for the support of new projects in Regions I, II, IV, V, IX, and X.

Estimated Range of Awards: \$3,300-\$123,400.

Estimated Average Size of Awards: \$48,000.

Estimated Number of Awards: 37.

Note: The Department is not bound by any estimates in this notice.

Project Period: Up to 36 months.

Applicable Regulations: (a) The Education Department General Administrative Regulations (EDGAR) in 34 CFR parts 74, 75, 77, 79, 80, 81, 82, 85, and 86; and (b) The regulations for this program in 34 CFR parts 385 and 388.

For Applications or Information Contact: Bruce Rose, U.S. Department of Education, 400 Maryland Avenue, SW., room 3332, Switzer Building, Washington, DC 20202-2649. To request an application, call (202) 732-1347; to receive further information, call (202) 732-1325. Deaf and hearing impaired individuals may call the Federal Dual Party Relay Service at 1-800-877-0339 (in the Washington, DC 202 area code, telephone 708-9300) between 8 a.m. and 7 p.m., Eastern time.

Program Authority: 29 U.S.C. 774.

Dated: November 18, 1991.

Michael E. Vader,

Acting Assistant Secretary, Office of Special Education and Rehabilitative Services.

[FR Doc. 91-28167 Filed 11-22-91; 8:45 am]

BILLING CODE 4000-01-M

National Council on Education Standards and Testing; Notice of Meetings

AGENCY: National Council on Education Standards and Testing; Education.

ACTION: Notice of meetings.

SUMMARY: This notice sets forth the schedule and agenda of forthcoming meetings of the National Council on Education Standards and Testing. This notice also describes the functions of the Council. Notice of these meetings is required under section 10(a)(2) of the Federal Advisory Committee Act.

DATE AND TIME: December 2, 1991; and December 16, 1991 from approximately 9:30 a.m. to 4:30 p.m.

ADDRESSES: Both meetings will be held at the Rayburn House Office Building, room 2175, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Elizabeth Barnes, 1850 M Street, NW., Suite 1050, Washington, DC 20036. Telephone: (202) 632-1032.

SUPPLEMENTARY INFORMATION: The National Council on Education Standards and Testing is established under section 403 of the Education Council Act of 1991 (20 U.S.C. 1221-1 note). The Council is established to provide advice on whether suitable specific education standards should and can be established and whether an appropriate system of voluntary

national tests or examinations should and can be established.

The meetings of the Council are open to the public. At the December 2 meeting, the Council will work to resolve issues on setting education standards for the Nation and planning a national assessment. Options for governance will also be discussed. At the December 16 meeting, the Council will review a draft of its report.

Records are kept of all Council proceedings, and are available for public inspection at the Office of the Council, 1850 M Street, NW., suite 1050, Washington, DC 20036 from the hours of 10 a.m. to 4 p.m.

Diane Ravitch,

Assistant Secretary, Educational Research and Improvement.

[FR Doc. 91-28392 Filed 11-22-91; 8:45 am]

BILLING CODE 4000-01-M

Office of Special Education and Rehabilitative Services

[CFDA No. 84.029B]

Notice Inviting Applications for New Awards Under Training Personnel for the Education of Individuals With Disabilities for Fiscal Year 1992

AGENCY: Department of Education.

ACTION: Correction notice.

SUMMARY: This notice corrects an error made in the application notice published in the *Federal Register* on November 7, 1991 at 56 FR 57205.

On page 57206, first column, under the Absolute Priority 3, Preparation for Careers in Special Education, CFDA No. 84.029B, at the end of the first paragraph, the last sentence was inadvertently added, "Training of administrators and supervisors at the masters level is also appropriate under this priority", this sentence should be deleted.

FOR FURTHER INFORMATION CONTACT: Max Mueller, DPP, Office of Special Education Programs, Department of Education, 400 Maryland Avenue, SW., Washington, DC 20202-2651. Telephone: (202) 732-1554. Deaf and hearing impaired individuals may call (202) 732-1100 for TDD services.

Authority: 20 U.S.C. 1431.

Dated: November 20, 1991.

Robert R. Davila,

Assistant Secretary, Office of Special Education and Rehabilitative Services.

[FR Doc. 91-28243 Filed 11-22-91; 8:45 am]

BILLING CODE 4000-01-M

DEPARTMENT OF ENERGY

Financial Assistance Award; Intent to Award Noncompetitive Cooperative Agreement to Cintichem, Inc.**AGENCY:** Department of Energy (DOE).**ACTION:** Notice of intent to make a noncompetitive financial assistance award.**SUMMARY:** DOE announces that, pursuant to 10 CFR 600.7, it is making a noncompetitive financial assistance award under a Cooperative Agreement to Cintichem, Inc. to preserve radiopharmaceutical technology for domestic diagnostic health care.**SCOPE:** Cintichem, Inc. shut down its research reactor and the production of radioisotopes for diagnostic health care in February 1990, leaving the United States with no domestic source of important radioisotopes. The purpose of the proposed Cooperative Agreement is to allow the DOE Isotope Production & Distribution (IP&D) Program to receive the equipment, patents, and technology from Cintichem in order to assure a continued reliable supply of the vital isotopes. Cintichem will ship the required equipment to Los Alamos National Laboratory and assist in the transfer of technology and processes to DOE IP&D. Under the proposed agreement, Cintichem would also ship its research reactor fuel assemblies to DOE for reprocessing and uranium recovery. Cintichem is in a unique position to effect this technology transfer since it is the only domestic producer and owner of the technology. DOE has determined it to be in the best interest of the public to preserve this technology and maintain a domestic supply source.**FOR FURTHER INFORMATION CONTACT:** U.S. Department of Energy, Office of Placement and Administration, ATTN: Richard E. Leotta, PR-322.2, 1000 Independence Avenue, SW., Washington, DC 20585.

Scott Sheffield,

Acting Director, Operations Division "B",
Office of Placement and Administration.

[FR Doc. 91-28269 Filed 11-22-91; 8:45 am]

BILLING CODE 6450-01-M

Energy Information Administration**Form EIA-819, Monthly Oxygenate Telephone Report****AGENCY:** Energy Information Administration, Department of Energy.**ACTION:** Notice of a proposed new monthly data collection EIA-819 on oxygenate production, imports, ending

stocks, and volumes blended into motor gasoline and solicitation of comments.

SUMMARY: The Energy Information Administration (EIA), as part of its continuing effort to reduce paperwork and respondent burden (required by the Paperwork Reduction Act of 1980, Pub. L. No. 96-511, 44 U.S.C. 3501 et seq.), conducts a presurvey consultation program to provide the general public and other Federal agencies with an opportunity to comment on proposed and/or continuing reporting forms. This program helps to ensure that requested data can be provided in the desired format, reporting burden is minimized, reporting forms are clearly understood, and the impact of collection requirements on respondents can be properly assessed. The purpose of this notice is to inform interested parties of proposed Form EIA-819, "Monthly Oxygenate Telephone Report," and to solicit comments on this form. This collection is designed to measure the monthly production, imports, and stocks of oxygenates in 1992 and to monitor the volumes of oxygenates used in the blending of motor gasoline to meet the Clean Air Act of 1990 requirements.**DATES:** Written comments must be submitted on or before December 16, 1991. If you anticipate that you will be submitting comments, but find it difficult to do so within the period of time allowed by this notice, you should advise the contact listed below of your intention to do so as soon as possible.**ADDRESSES:** Send comments to: Ms. Susan Harris (E1-421), Energy Information Administration, U.S. Department of Energy, Mail Stop: 2H-058, 1000 Independence Avenue, SW., Washington, DC 20585, Telephone: (202) 586-8364, FAX: (202) 586-5846.**FOR FURTHER INFORMATION OR TO OBTAIN COPIES OF THE PROPOSED FORM AND INSTRUCTIONS:** Requests for additional information or a copy of the proposed form and instructions should be directed to Ms. Harris at the address listed above.**SUPPLEMENTARY INFORMATION:**

- I. Background
- II. Current Actions
- III. Request for Comments

I. Background

In order to fulfill its responsibilities under the Federal Energy Administration Act of 1974 (Pub. L. No. 93-275) and the Department of Energy Organization Act (Pub. L. No. 95-91), the EIA is obliged to carry out a central, comprehensive, and unified energy data and information program. Under this program, EIA will collect, evaluate,

assemble, analyze, and disseminate data and information related to energy resource reserves, production, demand, and technology, as well as, related economic and statistical information relevant to the adequacy of energy resources to meet demands in the near and longer term future for the Nation's economic and social needs. The EIA is obliged to publish and otherwise make available to the public, high-quality statistical data that reflect current and regional petroleum supply activity.

The Clean Air Act (CAA), as amended (42 U.S.C. 7401 et seq.), has been further amended by Public Law No. 100-549, enacted on November 15, 1990. Section 219 of the 1990 amendment adds subsection (k) to section 211 of the CAA. Subsection (k) provides in 6(b) thereunder, that the Environmental Protection Agency Administrator, after consultation with the Secretary of Energy, will determine if there is sufficient domestic capacity to produce certified motor gasoline to meet the CAA requirements and act in accordance with that determination as the law allows. To help the EPA Administrator meet these responsibilities, as well as internal Department of Energy requirements that are dependent on accurate data, the EIA conducts statistical surveys that encompass each significant primary petroleum supply activity in the United States.

II. Current Actions

This will be a monthly collection to begin in January 1992 and continue for the remainder of 1992 to measure the production, imports, and stocks of oxygenates and to monitor the volumes of oxygenates used in the blending of motor gasoline to meet the requirements of the Clean Air Act of 1990. Data will be collected on a monthly basis by telephone or facsimile from a sample of companies selected by the EIA who: (1) Operate facilities that produce (manufacture or distill) oxygenates (including methyl tertiary butyl ether (MTBE) plants, petrochemical plants, and refineries that produce oxygenates as part of their operations); (2) operate refineries and blending plants; (3) operate bulk terminals, bulk stations, blending plants, and other non-refinery facilities that store and/or blend oxygenates; and (4) import oxygenates (importer of record) into the 50 States and the District of Columbia. Telephone calls to respondents will start on the third working day following the end of the report period with data being published approximately fifteen working days after the end of the report period.

Data on production, imports, and stocks will be collected by Petroleum Administration for Defense (PAD) Districts I through V for the following oxygenates: Fuel ethanol, ethyl tertiary butyl ether (ETBE), methanol, MTBE, tertiary amyl methyl ether (TAME), tertiary butyl alcohol (TBA), and other oxygenates.

III. Request for Comments

Prospective respondents and other interested parties should comment on the proposed survey. The following general guidelines are provided to assist in the preparation of responses.

As a Potential Respondent

A. Are the instructions and definitions clear and sufficient? If not, which instructions require clarification?

B. Can the data be submitted using the definitions included in the instructions?

C. Can the data be submitted in accordance with the response time specified in the instructions?

D. Public reporting burden for this collection is estimated to average 1/2 hour per response. How many hours, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information, do you estimate it will require you to complete and submit the required form?

E. What is the estimated cost of completing this form, including the direct and indirect costs associated with the data collection? Costs should include all costs, directly attributable to providing this information.

F. How can the form be improved?

G. Do you know of any other Federal, State, or local agency that collects similar data? If you do, specify the agency, the data element(s), and the means of collection.

As a Potential User

A. Can you use data at the levels of detail indicated on the form?

B. For what purpose would you use the data? Be specific.

C. How could the form be improved to better meet your specific needs?

D. Are there alternate sources of data and do you use them? What are their deficiencies and/or strengths?

The EIA is also interested in receiving comments from persons regarding their

views on the need for the information contained in the proposed collection.

Comments submitted in response to this notice will be summarized and/or included in the request for Office of Management and Budget approval of the form and will become a matter of public record.

Statutory Authority: Sections 5(a), 5(b), 13(b), and 52 of Pub. L. No. 93-275, Federal Energy Administration Act of 1974, 15 U.S.C. subsections 764(a), 764(b), 772(b), and 790a.

Issued in Washington, DC, November 18, 1991.

Yvonne M. Bishop,

Director, Statistical Standards, Energy Information Administration.

[FR Doc. 91-28276 Filed 11-22-91; 8:45 am]

BILLING CODE 6450-01-M

Federal Energy Regulatory Commission

[Docket Nos. ST91-10234-000 Through ST91-10630-000]

Pacific Gas Transmission Co.; Self-Implementing Transactions

November 18, 1991.

Take notice that the following transactions have been reported to the Commission as being implemented pursuant to part 284 of the Commission's regulations, sections 311 and 312 of the Natural Gas Policy Act of 1978 (NGPA) and section 5 of the Outer Continental Shelf Lands Act.¹

The "Recipient" column in the following table indicates the entity receiving or purchasing the natural gas in each transaction.

The "part 284 subpart" column in the following table indicates the type of transaction.

A "B" indicates transportation by an interstate pipeline on behalf of an intrastate pipeline or a local distribution company pursuant to § 284.102 of the Commission's regulations and section 311(a)(1) of the NGPA.

A "C" indicates transportation by an intrastate pipeline on behalf of an interstate pipeline or a local distribution

¹ Notice of a transaction does not constitute a determination that the terms and conditions of the proposed service will be approved or that the noticed filing is in compliance with the Commission's regulations.

company served by an interstate pipeline pursuant to § 284.122 of the Commission's regulations and section 311(a)(2) of the NGPA.

A "D" indicates a sale by an intrastate pipeline to an interstate pipeline or a local distribution company served by an interstate pipeline pursuant to § 284.142 of the Commission's Regulations and section 311(b) of the NGPA. Any interested person may file a complaint concerning such sales pursuant to § 284.147(d) of the Commission's Regulations.

An "E" indicates an assignment by an intrastate pipeline to any interstate pipeline or local distribution company pursuant to § 284.163 of the Commission's regulations and section 312 of the NGPA.

A "G" indicates transportation by an interstate pipeline on behalf of another interstate pipeline pursuant to § 284.222 and a blanket certificate issued under § 284.221 of the Commission's regulations.

A "G-S" indicates transportation by interstate pipelines on behalf of shippers other than interstate pipelines pursuant to § 284.223 and a blanket certificate issued under § 284.221 of the Commission's regulations.

A "G-LT" or "G-LS" indicates transportation, sales or assignments by a local distribution company on behalf of or to an interstate pipeline or local distribution company pursuant to a blanket certificate issued under § 284.224 of the Commission's regulations.

A "G-HT" or "G-HS" indicates transportation, sales or assignments by a Hinshaw Pipeline pursuant to a blanket certificate issued under § 284.224 of the Commission's regulations.

A "K" indicates transportation of natural gas on the Outer Continental Shelf by an interstate pipeline on behalf of another interstate pipeline pursuant to § 284.303 of the Commission's regulations.

A "K-S" indicates transportation of natural gas on the Outer Continental Shelf by an intrastate pipeline on behalf of shippers other than interstate pipelines pursuant to § 284.303 of the Commission's regulations.

Lois D. Cashell,
Secretary.

Docket Number ¹	Transporter/seller	Recipient	Date filed	Part 284 subpart	Est. max. daily quantity ²	Aff. Y/N	Rate sch.	Date commenced	Projected termination date
ST91-10234	Pacific Gas Transmission Co.	Northern California Power Agency.	09-03-91	G-S	41,000	N	I	07-14-91	06-01-91

Docket Number ¹	Transporter/seller	Recipient	Date filed	Part 284 subpart	Est. max. daily quantity ²	Aff. Y/N	Rate sch.	Date commenced	Projected termination date
ST91-10235	Northwest Pipeline Corp...	Enron Gas Marketing, Inc.	09-03-91	G-S	25,000	N	F	07-01-91	10-28-91
ST91-10236	Northwest Pipeline Corp...	Bonneville Fules Marketing Corp.	09-03-91	G-S	2,400	N	F	07-01-91	10-28-91
ST91-10237	Northwest Pipeline Corp...	Williams Gas Marketing Co.	09-03-91	G-S	100,000	N	F	07-01-91	10-28-91
ST91-10238	Northwest Pipeline Corp...	ARCO Natural Gas Marketing, Inc.	09-03-91	G-S	70,000	N	F	07-01-91	10-28-91
ST91-10239	Florida Gas Transmission Co.	Peoples Gas System, Inc.	09-03-91	B	967	N	I	08-01-91	Indef.
ST91-10240	Florida Gas Transmission Co.	Kissimmee Utility Authority.	09-03-91	G-S	706	N	I	08-01-91	11-28-91
ST91-10241	Florida Gas Transmission Co.	City of Homestead.....	09-03-91	G-S	1,042	N	I	08-01-91	11-28-91
ST91-10242	Florida Gas Transmission Co.	Chesapeake Utilities Corp.	09-03-91	B	11,224	N	F	08-01-91	Indef.
ST91-10243	Endevco Industrial Gas Sales Co.	Transcontinental Gas P/L, et al.	09-03-91	G-ST	10,000	N	N/A	08-01-91	10-31-05
ST91-10244	Endevco Industrial Gas Sales Co.	Elizabethtown Gas Co.....	09-03-91	G-ST	10,000	N	N/A	08-01-91	10-31-05
ST91-10245	Endevco Industrial Gas Sales Co.	Transcontinental Gas P/L, et al.	09-03-91	G-ST	10,000	N	N/A	08-01-91	10-31-05
ST91-10246	ANR Pipeline Co.....	Indeck-lion L P.....	09-03-91	G-S	13,600	N	F	07-01-91	10-28-91
ST91-10247	Panhandle Eastern Pipe Line Co.	Indiana Gas Co.....	09-03-91	B	2,000	N	I	08-01-91	Indef.
ST91-10248	Panhandle Eastern Pipe Line Co.	O & R Energy, Inc.....	09-03-91	G-S	50,000	N	I	08-01-91	11-29-91
ST91-10249	Panhandle Eastern Pipe Line Co.	City of Montgomery City....	09-03-91	G-S	1,400	N	I	08-01-91	11-29-91
ST91-10250	Acadian Gas Pipeline System.	Sea Robin Pipeline Co.....	09-03-91	C	40,000	N	F	05-01-91	Indef.
ST91-10251	Tennessee Gas Pipeline Co.	City of Olive Hill.....	09-03-91	B	20,000	N	I	08-01-91	Indef.
ST91-10252	Tennessee Gas Pipeline Co.	City of Morehead.....	09-03-91	B	20,000	N	I	08-01-91	Indef.
ST91-10253	Tennessee Gas Pipeline Co.	New York State Electric & Gas Co.	09-03-91	B	20,000	N	I	08-01-91	Indef.
ST91-10254	Tennessee Gas Pipeline Co.	Columbia Gas Transmission Corp.	09-03-91	G	20,000	N	I	08-01-91	Indef.
ST91-10255	Gas Transport, Inc.....	Hope Gas, Inc.....	09-03-91	B	1,600	N	F	08-01-91	Indef.
ST91-10256	Gas Transport, Inc.....	Hope Gas, Inc.....	09-03-91	B	6,000	N	F	08-01-91	Indef.
ST91-10257	Gas Transport, Inc.....	River Gas Co.....	09-03-91	G	1,000	N	I	03-20-91	Indef.
ST91-10258	Gas Transport, Inc.....	Hope Gas, Inc.....	09-03-91	B	1,000	N	F	08-01-91	Indef.
ST91-10259	Transcontinental Gas P/L Corp.	Delmarva Power and Light Co.	09-03-91	B	700,000	N	I	11-01-88	Indef.
ST91-10260	Transcontinental Gas P/L Corp.	Mississippi Fuel Co.....	09-03-91	B	250,000	N	I	08-01-91	11-28-91
ST91-10261	Transcontinental Gas P/L Corp.	City Of Royston.....	09-03-91	B	140,000	N	I	06-06-91	Indef.
ST91-10262	Transcontinental Gas P/L Corp.	Long Island Lighting Co....	09-03-91	B	1,925,000	N	I	11-01-91	Indef.
ST91-10263	Transcontinental Gas P/L Corp.	Stand Energy Corp.....	09-03-91	G-S	3,200	N	I	07-30-91	11-26-91
ST91-10264	Transcontinental Gas P/L Corp.	Seagull Marketing Services, Inc.	09-03-91	G-S	250,000	N	I	08-01-91	11-28-91
ST91-10265	Transcontinental Gas P/L Corp.	OXY U.S.A., Inc.....	09-03-91	G-S	370,600	N	I	08-01-91	11-28-91
ST91-10266	Transcontinental Gas P/L Corp.	Mobile Natural Gas, Inc....	09-03-91	G-S	825,000	N	I	08-01-91	11-28-91
ST91-10267	Transcontinental Gas P/L Corp.	Amerada Hess Corp.....	09-03-91	G-S	1,500,000	N	I	08-01-91	11-28-91
ST91-10268	Transcontinental Gas P/L Corp.	Catex Energy, Inc.....	09-03-91	G-S	250,000	N	I	08-01-91	11-28-91
ST91-10269	Transcontinental Gas P/L Corp.	Chevron U.S.A., Inc.....	09-03-91	G-S	1,700,000	N	I	08-01-91	11-28-91
ST91-10270	Transcontinental Gas P/L Corp.	Coastal Gas Marketing Co.	09-03-91	G-S	1,000,000	N	I	08-01-91	11-28-91
ST91-10271	Transcontinental Gas P/L Corp.	Conoco, Inc.....	09-03-91	G-S	500,000	N	I	08-01-91	11-28-91
ST91-10272	Transcontinental Gas P/L Corp.	Enron Gas Marketing, Inc.	09-03-91	G-S	1,000,000	N	I	08-01-91	11-28-91
ST91-10273	Transcontinental Gas P/L Corp.	Municipal Gas Authority of Georgia.	09-03-91	G-S	200,000	N	I	08-01-91	11-28-91
ST91-10274	Transcontinental Gas P/L Corp.	O & O Energy, Inc.....	09-03-91	G-S	500,000	N	I	08-01-91	11-28-91
ST91-10275	Transcontinental Gas P/L Corp.	Phillips Petroleum Co.....	09-03-91	G-S	400,000	N	I	08-01-91	11-28-91
ST91-10276	Transcontinental Gas P/L Corp.	Shell Gas Trading Co.....	09-03-91	G-S	1,150,000	N	I	08-01-91	11-28-91

Docket Number	Transporter/seller	Recipient	Date filed	Part 284 subpart	Est. max. daily quantity	Aff. Y/N	Rate sch.	Date commenced	Projected termination date
ST91-10277	Transcontinental Gas P/L Corp.	Tenngasco Corp.	09-03-91	G-S	900,000	N	I	08-01-91	11-28-91
ST91-10278	Transcontinental Gas P/L Corp.	Union Pacific Fuels, Inc.	09-03-91	G-S	550,000	N	I	08-01-91	11-28-91
ST91-10279	Transcontinental Gas P/L Corp.	Unocal Corp.	09-03-91	G-S	480,000	N	I	08-01-91	11-28-91
ST91-10280	Transcontinental Gas P/L Corp.	Texaco Gas Marketing, Inc.	09-03-91	G-S	5,000,000	N	I	08-01-91	11-28-91
ST91-10281	Transcontinental Gas P/L Corp.	Superior Natural Gas Corp.	09-03-91	G-S	150,000	N	I	08-01-91	11-28-91
ST91-10282	Transcontinental Gas P/L Corp.	Aquila Energy Marketing	09-03-91	G-S	1,500,000	N	I	08-01-91	11-28-91
ST91-10283	Transcontinental Gas P/L Corp.	Bishop Pipeline Corp.	09-03-91	G-S	500,000	N	I	08-01-91	11-28-91
ST91-10284	Transcontinental Gas P/L Corp.	FINA Natural Gas Co.	09-03-91	G-S	525,000	N	I	08-01-91	11-28-91
ST91-10285	Transcontinental Gas P/L Corp.	Enmark Gas Corp.	09-03-91	G-S	150,000	N	I	08-01-91	11-28-91
ST91-10286	Transcontinental Gas P/L Corp.	Stellar Gas Co.	09-03-91	G-S	250,000	N	I	08-01-91	11-28-91
ST91-10287	Transcontinental Gas P/L Corp.	B & C Oil Co.	09-03-91	G-S	1,000	N	I	08-20-91	11-17-91
ST91-10288	Tennessee Gas Pipeline Co.	Peoples Natural Gas Co.	09-04-91	G-S	50,000	N	I	08-08-91	12-06-91
ST91-10289	Channel Industries Gas Co.	Natural Gas P/L Co. of America.	09-04-91	C	20,000	N	I	08-30-91	Indef.
ST91-10290	Transwestern Pipeline Co.	Westar Transmission Co.	09-04-91	G-S	40,000	N	I	08-06-91	12-04-91
ST91-10291	Mississippi River Trans. Corp.	Louisville Gas and Electric Co.	09-04-91	B	30,000	N	I	07-01-91	Indef.
ST91-10292	Arkla Energy Resources	Williams Gas Marketing Co.	09-04-91	G-S	100,000	N	I	12-12-90	04-13-91
ST91-10293	Columbia Gas Transmission Corp.	Baltimore Gas & Electric Co.	09-04-91	B	20,000	Y	I	08-23-91	Indef.
ST91-10294	Transcontinental Gas P/L Corp.	Ashland Gas Marketing, Inc.	09-04-91	G-S	8,133,000	N	I	08-01-91	11-28-91
ST91-10295	Natural Gas P/L Co. of America.	Iowa-Illinois Gas and Elect. Co.	09-04-91	B	3,000	N	F	08-15-91	02-28-95
ST91-10296	Natural Gas P/L Co. of America.	Iowa-Illinois Gas and Elect. Co.	09-04-91	B	4,000	N	F	08-15-91	02-28-95
ST91-10297	Texas Gas Transmission Corp.	Seagull Marketing Services, Inc.	09-04-91	G-S	20,000	N	I	08-25-91	12-22-91
ST91-10298	Texas Gas Transmission Corp.	Seagull Marketing Services, Inc.	09-04-91	G-S	20,000	N	I	08-25-91	12-22-91
ST91-10299	ANR Pipeline Co.	Monterey Pipeline Co.	09-04-91	B	100,000	N	I	01-11-91	08-01-91
ST91-10300	ANR Pipeline Co.	Central Illinois Light Co.	09-04-91	B	150,000	N	I	08-01-91	Indef.
ST91-10301	ANR Pipeline Co.	Columbia Gas of KY, Inc.	09-04-91	B	50,000	N	I	08-01-91	Indef.
ST91-10302	ANR Pipeline Co.	Columbia Gas of Ohio, Inc.	09-04-91	B	2,500	N	I	08-01-91	Indef.
ST91-10303	ANR Pipeline Co.	ELF Aquitaine Operating, Inc.	09-04-91	G-S	5,000	N	I	08-20-91	12-17-91
ST91-10304	ANR Pipeline Co.	Northern Indiana Public Service Co.	09-04-91	B	150,000	N	I	08-14-91	Indef.
ST91-10305	ANR Pipeline Co.	Tejas Hydrocarbons Co.	09-04-91	G-S	100,000	N	I	08-15-91	12-12-91
ST91-10306	ANR Pipeline Co.	Northern Illinois Gas Co.	09-04-91	B	20,000	N	I	08-23-91	Indef.
ST91-10307	ONG Transmission Co.	Ozark Pipeline Co.	08-06-91	C	50,000	N	I	08-09-91	09-08-93
ST91-10308	Algonquin Gas Transmission Co.	Entrade Corp.	09-06-91	G-S	200,000	N	I	08-06-91	12-04-91
ST91-10309	Texas Eastern Transmission Corp.	Sonat Marketing Co.	09-06-91	G-S	25,000	N	I	08-01-91	11-01-92
ST91-10310	United Gas Pipe Line Co.	Rally Pipeline Corp.	09-06-91	G-S	58,710	N	I	08-27-91	12-25-91
ST91-10311	United Gas Pipe Line Co.	O & R Energy, Inc.	09-06-91	G-S	20,600	N	I	08-27-91	12-25-91
ST91-10312	Columbia Gas Transmission Corp.	Gas Transport, Inc.	09-06-91	G	20,500	Y	I	08-01-91	Indef.
ST91-10313	Columbia Gas Transmission Corp.	Gas Transport, Inc.	09-06-91	G	1,650	Y	F	08-01-91	Indef.
ST91-10314	Columbia Gas Transmission Corp.	Gas Transport, Inc.	09-06-91	G	6,250	Y	F	08-01-91	Indef.
ST91-10315	Columbia Gas Transmission Corp.	Gas Transport, Inc.	09-06-91	G	1,000	Y	F	08-01-91	08-30-92
ST91-10316	Southern Natural Gas Co.	Access Energy Corp.	09-06-91	G-S	3,000	N	I	08-01-91	11-29-91
ST91-10317	Southern Natural Gas Co.	NGC Transportation, Inc.	09-06-91	G-S	100,000	N	I	08-01-91	11-29-91
ST91-10318	Southern Natural Gas Co.	Bishop Pipeline Corp.	09-06-91	G-S	100,000	N	I	08-01-91	11-29-91
ST91-10319	Arkla Energy Resources	Arco Oil and Gas Co.	09-09-91	G-S	150,000	N	I	06-15-91	10-14-91
ST91-10320	Arkla Energy Resources	Mega Natural Gas Co.	09-09-91	G-S	150,000	N	I	08-03-91	12-02-91
ST91-10321	Natural Gas P/L Co. of America.	Access Energy Corp.	09-09-91	G-S	100,000	N	I	08-10-91	12-08-91

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ST91-10322	Natural Gas P/L Co. of America.	KN Gas Marketing, Inc.....	09-09-91	G-S	50,000	N	I	08-16-91	12-14-91
ST91-10323	Natural Gas P/L Co. of America.	Access Energy Corp.....	09-09-91	G-S	100,000	N	I	08-15-91	12-13-91
ST91-10324	Transcontinental Gas P/L Corp.	Fort Hill Natural Gas Authority.	09-09-91	B	11,900	N	F	04-01-91	10-31-04
ST91-10325	Panhandle Eastern Pipeline Co.	ANR Gathering Co.....	09-09-91	G-S	100,000	N	I	08-23-91	12-21-91
ST91-10326	Panhandle Eastern Pipeline Co.	Coastal Gas Marketing Co.	09-09-91	G-S	50,000	N	I	08-22-91	12-20-91
ST91-10327	Panhandle Eastern Pipeline Co.	Getty Gas Gathering, Inc..	09-09-91	B	10,000	N	I	08-23-91	Indef.
ST91-10328	Northern Natural Gas Co..	Enron Gas Marketing, Inc.	09-09-91	G-S	500,000	Y	F/I	08-20-91	12-18-91
ST91-10329	Northern Natural Gas Co..	Panda Resources, Inc.....	09-09-91	G-S	25,000	N	F	08-08-91	12-06-91
ST91-10330	Northern Natural Gas Co..	North Canadian Marketing Corp.	09-09-91	G-S	100,000	N	F/I	08-21-91	12-19-91
ST91-10331	Northern Natural Gas Co..	Kerr-McGee Corp.....	09-09-91	G-S	88,457	N	F/I	08-25-91	12-23-91
ST91-10332	Transwestern Pipeline Co.	Premier Gas Co.....	09-09-91	G-S	20,000	N	I	08-01-91	12-30-91
ST91-10333	Transwestern Pipeline Co.	Centran Corp.....	09-09-91	G-S	25,000	N	I	08-01-91	12-30-91
ST91-10334	Trunkline Gas Co.....	CMS Gas Marketing Co....	09-09-91	G-S	55,174	N	I	08-20-91	12-18-91
ST91-10335	Trunkline Gas Co.....	Dayton Power and Light Co.	09-09-91	B	100,000	N	I	08-15-91	12-14-91
ST91-10336	Trunkline Gas Co.....	Bishop Pipeline Corp.....	09-09-91	G-S	20,000	N	I	08-15-91	12-13-91
ST91-10337	Trunkline Gas Co.....	NGC Transportation, Inc...	09-09-91	G-S	5,000	N	I	08-16-91	12-14-91
ST91-10338	Tennessee Gas Pipeline Co.	Channel Industries Gas Co.	09-10-91	B	2,500	Y	I	08-03-91	Indef.
ST91-10339	El Paso Natural Gas Co....	Shell Western E & P, Inc..	09-10-91	G-S	25,750	N	I	08-23-91	12-21-91
ST91-10340	El Paso Natural Gas Co....	Panda Resources, Inc.....	09-10-91	G-S	10,300	N	I	08-16-91	12-14-91
ST91-10341	Traillblazer Pipeline Co....	Grand Valley Gas Co.....	09-10-91	G-S	353,000	N	I	08-24-91	12-22-91
ST91-10342	Natural Gas P/L Co. of America.	Arkla Energy Marketing Co.	09-10-91	G-S	100,000	N	I	08-13-91	12-11-91
ST91-10343	Stingray Pipeline Co.....	CHG Trading Co.....	09-10-91	K-S	50,000	N	I	08-15-91	12-13-91
ST91-10344	Enogex Inc.....	Phillips Gas Pipeline Co....	09-10-91	C	50,000	N	I	08-01-91	Indef.
ST91-10345	United Gas Pipe Line Co..	Crescent Gas Corp.....	09-10-91	G-S	5,150	N	I	08-26-91	12-24-91
ST91-10346	United Gas Pipe Line Co..	Cowboy Pipeline Service..	09-10-91	G-S	5,150	N	I	08-21-91	09-20-91
ST91-10347	United Gas Pipe Line Co..	Fina Natural Gas Co.....	09-10-91	G-S	103,000	N	I	08-21-91	09-19-91
ST91-10348	United Gas Pipe Line Co..	Harbert Oil & Gas Corp....	09-10-91	G-S	15,450	N	I	08-27-91	12-25-91
ST91-10349	United Gas Pipe Line Co..	Arkla Energy Marketing Co.	09-10-91	G-S	1,143	N	I	08-27-91	12-25-91
ST91-10350	Northwest Pipeline Corp...	Canwest Gas Supply U.S.A., Inc.	09-10-91	G-S	2,500	N	I	08-09-91	12-06-91
ST91-10351	Southern Natural Gas Co.	Coast Energy Group, Inc..	09-10-91	G-S	50,000	N	I	08-29-91	12-27-91
ST91-10352	Texas Gas Transmission Corp.	City of Dyersburg.....	09-10-91	B	6,558	N	F	09-01-91	Indef.
ST91-10353	Texas Gas transmission Corp.	Riverside Pipeline Co.....	09-10-91	B	20,000	N	I	09-01-91	Indef.
ST91-10354	Texas Gas Transmission Corp.	Southern Indiana Gas & Elect. Co.	09-10-91	B	51,000	N	F	09-01-91	Indef.
ST91-10355	Texas Gas Transmission Corp.	Lawrenceburg Gas Co.....	09-10-91	B	5,500	N	F	09-01-91	Indef.
ST91-10356	Natural Gas P/L Co of America.	American Central Gas Cos., Inc.	09-11-91	G-S	200,000	N	I	08-26-91	12-24-91
ST91-10357	Tennessee Gas Pipeline Co.	East Ohio Gas Co.....	09-11-91	B	20,000	N	I	08-22-91	Indef.
ST91-10358	Tennessee Gas Pipeline Co.	Consolidated Edison Co. of NY, Inc.	09-11-91	B	328,667	N	I	08-22-91	Indef.
ST91-10359	Stingray Pipeline Co.....	Anadarko Trading Co.....	09-11-91	K-S	100,000	N	I	08-22-91	12-20-91
ST91-10360	Arkla Energy Resources...	Coastal Gas Marketing Co.	09-11-91	G-S	100,000	N	I	08-03-91	12-02-91
ST91-10361	Colorado Interstate Gas Co.	Phone-Poulenic Pipeline Co.	09-11-91	B	400	N	I	08-01-91	Indef.
ST91-10362	Tennessee Gas Pipeline Co.	Colonial Gas Co.....	09-11-91	B	13,900	N	I	08-20-91	Indef.
ST91-10363	Delhi Gas Pipeline Corp....	El Paso Natural Gas Co....	09-12-91	C	9,000	N	I	08-13-91	Indef.
ST91-10364	CNG Transmission Corp...	Meridian Marketing & Trans. Corp.	09-12-91	G-S	1,800	N	I	08-17-91	12-15-91
ST91-10365	Texas Gas Transmission Corp.	Mississippi Valley Gas Co.	09-12-91	B	41,264	N	F	09-01-91	Indef.
ST91-10366	Texas Gas Transmission Corp.	Western Kentucky Gas Co.	09-12-91	B	40,500	N	F	09-01-91	Indef.
ST91-10367	Texas Gas Transmission Corp.	Mobile Natural Gas Inc....	09-12-91	G-S	14,200	N	I	09-01-91	12-29-91
ST91-10368	Texas Gas Transmission Corp.	Jackson Utility Division.....	09-12-91	B	12,000	N	F	09-01-91	Indef.
ST91-10369	Texas Gas Transmission Corp.	American Central Gas Marketing Co.	09-12-91	G-S	30,000	N	I	09-01-91	12-29-91

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ST91-10370	Texas Gas Transmission Corp.	Illinois Gas Co.....	09-12-91	B	3,117	N	F	09-01-91	Indef.
ST91-10371	Transco-Louisiana Intra P/L Co.	Texas Gas Transmission Corp.	09-12-91	C	200,000	N	I	06-01-91	Indef.
ST91-10372	United Gas Pipe Line Co.	Midcon Marketing Corp.....	09-12-91	G-S	721,000	N	I	09-03-91	01-01-92
ST91-10373	United Gas Pipe Line Co.	Centran Corp.....	09-12-91	G-S	20,600	N	I	09-05-91	01-03-92
ST91-10374	United Gas Pipe Line Co.	Eagle Natural Gas Co.....	09-12-91	G-S	25,750	N	I	09-04-91	01-02-91
ST91-10375	United Gas Pipe Line Co.	Olympic Pipeline Co.....	09-12-91	B	20,600	N	I	09-01-91	Indef.
ST91-10376	United Gas Pipe Line Co.	O & R Energy, Inc.....	09-12-91	G-S	30,900	N	I	08-26-91	12-24-91
ST91-10377	Dow Pipeline Co.....	TPC Transmission, Inc.....	09-13-91	C	30,900	N	I	09-01-91	09-01-93
ST91-10378	Arkla Energy Resources...	North Canadian Marketing Co.	09-13-91	G-S	10,000	N	I	09-01-91	12-30-91
ST91-10379	Columbia Gas Transmission Corp.	Vinyard Oil and Gas Co....	09-13-91	G-S	1,000	N	I	09-10-91	01-08-91
ST91-10380	Columbia Gas Transmission Corp.	Woodward Marketing, Inc.	09-13-91	G-S	50,000	N	I	09-01-91	12-30-91
ST91-10381	Columbia Gas Transmission Corp.	Manville Sales Corp.....	09-13-91	G-S	1,000	N	F	09-01-91	12-30-91
ST91-10382	Columbia Gas Transmission Corp.	Manville Sales Corp.....	09-13-91	G-S	2,500	N	I	09-01-91	12-30-91
ST91-10383	Tennessee Gas Pipeline Co.	Stellar Gas Co.....	09-13-91	G-S	10,000	N	I	08-14-91	12-12-91
ST91-10384	Colorado Interstate Gas Co.	Coastal Gas Marketing Co.	09-13-91	G-S	100,000	N	I	08-01-91	11-29-91
ST91-10385	Wyoming Interstate Gas Co.	Northern Indiana Public Service Co.	09-13-91	B	50,000	N	I	08-24-91	08-01-92
ST91-10386	Transcontinental Gas P/L Corp.	Philadelphia Electric Co....	09-13-91	B	40,000	N	I	01-10-91	Indef.
ST91-10387	Transcontinental Gas P/L Corp.	Atlanta Gas Light Co.....	09-13-91	B	178,100	N	I	12-21-90	Indef.
ST91-10388	Transcontinental Gas P/L Corp.	Frederick Gas Co., Inc.....	09-13-91	B	4,500	N	I	04-01-91	03-31-05
ST91-10389	Transcontinental Gas P/L Corp.	Corpus Christi Transmission Co.	09-13-91	B	243,000	N	I	11-06-90	Indef.
ST91-10390	Tennessee Gas Pipeline Co.	Commonwealth Gas Co....	09-16-91	B	10,000	N	F	09-02-91	11-01-00
ST91-10391	Colorado Interstate Gas Co.	Western Gas Resources, Inc.	09-16-91	G-S	50,000	N	I	08-01-91	11-29-91
ST91-10392	Colorado Interstate Gas Co.	Coastal Chem, Inc.....	09-16-91	G-S	14,000	Y	F	09-01-91	12-30-91
ST91-10393	ANR Pipeline Co.....	Niagara Mohawk Power Corp.	09-16-91	B	200,000	Y	I	08-23-91	Indef.
ST91-10394	ANR Pipeline Co.....	Texaco Gas Marketing, Inc.	09-16-91	G-S	50,000	N	I	08-28-91	12-25-91
ST91-10395	ANR Pipeline Co.....	Illinois Power Co.....	09-16-91	B	230,000	Y	I	08-27-91	Indef.
ST91-10396	ANR Pipeline Co.....	Coastal Gas Marketing Co.	09-16-91	G-S	250,000	Y	I	08-24-91	12-21-91
ST91-10397	Trunkline Gas Co.....	Indiana Gas Co.....	09-16-91	B	1,200	N	I	09-01-91	Indef.
ST91-10398	Tennessee Gas Pipeline Co.	United Gas Pipe Line Co..	09-17-91	G	1,000,000	N	I	07-01-91	Indef.
ST91-10399	Texas Eastern Transmission Corp.	Citizens Gas Supply Corp.	09-17-91	G-S	25,000	N	F	08-01-91	11-29-91
ST91-10400	Texas Eastern Transmission Corp.	CMEX Energy, Inc.....	09-17-91	G-S	25,000	N	F	08-01-91	11-29-91
ST91-10401	Texas Eastern Transmission Corp.	Conoco Inc.....	09-17-91	G-S	25,000	N	F	08-01-91	12-29-91
ST91-10402	Texas Eastern Transmission Corp.	Texaco Gas Marketing Inc.	09-17-91	G-S	25,000	N	F	08-01-91	11-29-91
ST91-10403	Wyoming Interstate Co., Ltd.	Colorado Interstate Gas Co.	09-17-91	B	100,000	Y	I	08-10-91	Indef.
ST91-10404	Transcontinental Gas P/L Corp.	Virginia Natural Gas, Inc...	09-17-91	B	19,324	N	F	04-01-91	03-31-05
ST91-10405	Transcontinental Gas P/L Corp.	Washington Gas Light Co.	09-17-91	B	55,000	N	F	04-01-91	03-31-00
ST91-10406	Transcontinental Gas P/L Corp.	Union Gas Co.....	09-17-91	B	10,350	Y	F	04-01-91	03-31-05
ST91-10407	Transcontinental Gas P/L Corp.	Piedmont Natural Gas Co., Inc.	09-17-91	B	141,560	Y	F	04-01-91	10-31-05
ST91-10408	Transcontinental Gas P/L Corp.	South Carolina Pipeline Corp.	09-17-91	B	20,000	Y	F	04-01-91	10-31-04
ST91-10409	Transcontinental Gas P/L Corp.	City of Shelby.....	09-17-91	B	5,600	Y	F	04-01-91	03-31-00
ST91-10410	Transcontinental Gas P/L Corp.	United Cities Gas Co.....	09-17-91	B	5,224	Y	F	04-01-91	03-31-98
ST91-10411	Tennessee Gas Pipeline Co.	Superior Natural Gas Corp.	09-18-91	B	80,000	N	I	09-01-91	Indef.
ST91-10412	Tennessee Gas Pipeline Co.	Industrial Energy Services Co.	09-18-91	G-S	30,000	N	I	08-01-91	11-29-81
ST91-10413	Tennessee Gas Pipeline Co.	Chevron USA, Inc.....	09-18-91	G-S	205,000	N	I	08-19-91	12-17-91

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ST91-10414	Tennessee Gas Pipeline Co.	Cranberry Pipeline Corp.	09-18-91	G-S	30,000	N	I	08-17-91	11-29-91
ST91-10415	Questar Pipeline Co.	Amoco Production Co.	09-18-91	G-S	16,000	N	I	09-04-91	01-01-92
ST91-10416	Northern Natural Gas Co.	Coast Energy Group, Inc.	09-18-91	G-S	88,457	N	F/I	09-11-91	01-09-92
ST91-10417	Northern Natural Gas Co.	Wisconsin Natural Gas Co.	09-18-91	B	100,000	N	F/I	09-02-91	Indef.
ST91-10418	Northern Natural Gas Co.	Wisconsin Natural Gas Co.	09-18-91	B	40,000	N	F/I	08-28-91	Indef.
ST91-10419	Northern Natural Gas Co.	Texaco Gas Marketing, Inc.	09-18-91	G-S	50,000	N	F/I	09-01-91	12-30-91
ST91-10420	Northern Natural Gas Co.	Central Soya Co., Inc.	09-18-91	G-S	4,000	N	F/I	08-27-91	12-26-91
ST91-10421	Llano, Inc.	Madison Gas & Electric Co.	09-18-91	C	5,610	N	F	09-01-91	Indef.
ST91-10422	United Gas Pipe Line Co.	Total Minatome Corp.	09-18-91	G-S	104,800	N	I	09-10-91	01-08-92
ST91-10423	Arkia Energy Resources	Clinton Gas Transmission, Inc.	09-18-91	G-S	20,000	N	I	07-01-91	10-29-91
ST91-10424	Mississippi River Trans. Corp.	O & R Energy, Inc.	09-18-91	G-S	1,000	N	F	08-21-91	12-19-91
ST91-10425	Mississippi River Trans. Corp.	TXG Gas Marketing Co.	09-18-91	B	50,000	Y	I	12-01-90	Indef.
ST91-10426	Transcontinental Gas P/L Corp.	City of Lexington	09-18-91	B	3,900	N	F	04-01-91	03-31-05
ST91-10427	Transcontinental Gas P/L Corp.	City of Laurens	09-18-91	B	3,135	N	F	04-01-91	03-31-00
ST91-10428	Transcontinental Gas P/L Corp.	North Carolina Natural Gas Corp.	09-18-91	B	86,957	Y	F	04-01-91	03-31-00
ST91-10429	Transcontinental Gas P/L Corp.	Pennsylvania Gas & Water Co.	09-18-91	B	26,900	N	F	04-01-91	03-31-04
ST91-10430	Transcontinental Gas P/L Corp.	Philadelphia Electric Co.	09-18-91	B	89,608	Y	F	04-01-91	03-31-04
ST91-10431	Transcontinental Gas P/L Corp.	Philadelphia Gas Works	09-18-91	B	77,295	Y	F	04-01-91	03-31-05
ST91-10432	Florida Gas Transmission Co.	Gold Bond Building Products	09-19-91	G-S	1,151	N	I	09-01-91	12-29-91
ST91-10433	Florida Gas Transmission Co.	Fort Pierce Utilities Authority	09-19-91	G-S	1,697	N	F	09-01-91	12-29-91
ST91-10434	Channel Industries Gas Co.	Sabine Pipe Line Co.	09-19-91	C	50,000	N	I	08-10-91	Indef.
ST91-10435	Tennessee Gas Pipeline Co.	United Texas Transmission Co.	09-19-91	B	80,000	N	I	08-03-91	Indef.
ST91-10436	East Tennessee Gas Pipeline Co.	Sweetwater Utilities Board	09-19-91	B	250,000	N	I	09-02-91	Indef.
ST91-10437	East Tennessee Gas Pipeline Co.	Atlanta Gas Light Co.	09-19-91	B	50,000	N	I	09-02-91	Indef.
ST91-10438	East Tennessee Gas Pipeline Co.	Atlanta Gas Light Co.	09-19-91	B	200,000	N	I	09-02-91	Indef.
ST91-10439	East Tennessee Gas Pipeline Co.	Chattanooga Gas Co.	09-19-91	B	200,000	N	I	09-02-91	Indef.
ST91-10440	East Tennessee Gas Pipeline Co.	Chattanooga Gas Co.	09-19-91	B	100,000	N	I	09-01-91	Indef.
ST91-10441	East Tennessee Gas Pipeline Co.	United Cities Gas Co.	09-19-91	B	100,000	N	I	09-01-91	Indef.
ST91-10442	East Tennessee Gas Pipeline Co.	Chattanooga Gas Co.	09-19-91	B	12,000	N	I	09-12-91	Indef.
ST91-10443	East Tennessee Gas Pipeline Co.	Atlanta Gas Light Co.	09-19-91	B	400,000	Y	I	09-01-91	Indef.
ST91-10444	East Tennessee Gas Pipeline Co.	City of Etowa Utilities	09-19-91	B	400,000	Y	I	09-01-91	Indef.
ST91-10445	ANR Pipeline Co.	Wisconsin Public Service Co.	09-19-91	B	5,000	N	I	09-01-91	08-31-94
ST91-10446	ANR Pipeline Co.	Wisconsin Power & Light Co.	09-19-91	B	100,000	N	I	09-02-91	Indef.
ST91-10447	ANR Pipeline Co.	Cincinnati Gas and Electric Co.	09-19-91	B	50,000	N	I	09-01-91	Indef.
ST91-10448	ANR Pipeline Co.	West Ohio Gas Co.	09-19-91	B	4,000	N	F	09-01-91	Indef.
ST91-10449	ANR Pipeline Co.	Michigan Gas Utilities	09-19-91	B	100,000	N	I	09-01-91	Indef.
ST91-10450	ANR Pipeline Co.	Panhandle Trading Co.	09-19-91	G-S	100,000	N	I	09-01-91	12-29-91
ST91-10451	ANR Pipeline Co.	Coastal Gas Marketing Co.	09-19-91	G-S	25,000	N	I	09-01-91	12-29-91
ST91-10452	Columbia Gulf Transmission Co.	Atlas Gas Marketing, Inc.	09-19-91	G-S	10,000	N	I	09-01-91	12-29-91
ST91-10453	Columbia Gulf Transmission Co.	Northeast Ohio Gas Marketing, Inc.	09-19-91	G-S	40,000	N	I	09-01-91	12-29-91
ST91-10454	Columbia Gulf Transmission Co.	Energy Development Corp.	09-19-91	G-S	200,000	N	I	09-01-91	12-29-91
ST91-10455	Columbia Gulf Transmission Co.	Stellar Gas Co.	09-19-91	G-S	60,000	N	I	09-01-91	12-29-91
ST91-10456	Transok, Inc.	Panhandle Eastern Pipe Line Co.	09-19-91	C	15,000	N	I	08-20-91	Indef.

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ST91-10457	Transok, Inc.....	Natural Gas P/L Co. of America.	09-19-91	C	20,000	N	I	08-23-91	Indef.
ST91-10458	El Paso Natural Gas Co....	Cmex Energy, Inc.....	09-20-91	G-S	82,400	Y	I	08-30-91	12-28-91
ST91-10459	Tennessee Gas Pipeline Inc.	City of Woodville.....	09-20-91	B	2,500	N	I	08-28-91	Indef.
ST91-10460	Arkla Energy Resources...	Premier Gas Co.....	09-20-91	G-S	60,000	N	I	08-10-91	11-09-91
ST91-10461	Columbia Gas Transmission Co.	GASCO, Inc.....	09-20-91	G-S	5,000	N	I	09-10-91	01-08-92
ST91-10462	Columbia Gas Transmission Co.	GASCO, Inc.....	09-20-91	G-S	5,000	N	I	09-16-91	01-14-92
ST91-10463	Florida Gas Transmission Co.	City of Lakeland.....	09-20-91	G-S	4,209	N	I	09-01-91	12-29-91
ST91-10464	Florida Gas Transmission Co.	Lake Apopka Natural Gas District.	09-20-91	G-S	2,165	N	F	09-01-91	12-29-91
ST91-10465	Florida Gas Transmission Co.	City Gas Co. of Florida.....	09-20-91	G-S	690	N	F/I	09-01-91	12-29-91
ST91-10466	Transcontinental Gas P/L Corp.	City of Bessemer City.....	09-20-91	B	1,000	N	F	04-01-91	03-05-99
ST91-10467	Transcontinental Gas P/L Corp.	Blacksburg Natural Gas System.	09-20-91	B	1,250	N	F	04-01-91	03-31-05
ST91-10468	Transcontinental Gas P/L Corp.	City of Danville.....	09-20-91	B	12,000	N	F	04-01-91	04-01-99
ST91-10469	Transcontinental Gas P/L Corp.	Eastern Shore Natural Gas Co.	09-20-91	B	18,900	Y	F	04-01-91	03-31-05
ST91-10470	Trunkline Gas Co.....	Indiana Gas Co.....	09-20-91	B	20,000	Y	I	09-01-91	10-01-91
ST91-10471	Trunkline Gas Co.....	Torch Energy Marketing, Inc.	09-20-91	G-S	5,000	N	I	09-01-91	10-01-91
ST91-10472	Trunkline Gas Co.....	Indiana Gas Co.....	09-20-91	B	1,000	N	I	09-01-91	Indef.
ST91-10473	Trunkline Gas Co.....	Indiana Gas Co.....	09-20-91	B	2,500	N	I	09-01-91	Indef.
ST91-10474	Trunkline Gas Co.....	Commonwealth Gas Co., et al.	09-20-91	B	125,000	Y	I	09-01-91	Indef.
ST91-10475	Trunkline Gas Co.....	Indiana Gas Co.....	09-20-91	B	1,050	N	I	09-01-91	Indef.
ST91-10476	Tennessee Gas Pipeline Co.	Westvaco Corp.....	09-20-91	G-S	7,000	N	I	09-04-91	01-02-92
ST91-10477	Tennessee Gas Pipeline Co.	Texas Eastern Transmission Corp.	09-20-91	G	3,200,000	N	I	04-01-91	Indef.
ST91-10478	Valero Transmission, L.P.	El Paso Natural Gas Co....	09-20-91	C	5,250	N	I	09-05-91	Indef.
ST91-10479	TransTexas Pipeline Co....	El Paso Natural Gas Co....	09-20-91	C	5,250	N	I	09-05-91	Indef.
ST91-10480	United Gas Pipe Line Co...	Prior Intrastate Corp.....	09-20-91	G-S	524,000	N	I	08-22-91	12-20-91
ST91-10481	ANR Pipeline Co.....	River Trading Co.....	09-23-91	G-S	75,000	N	I	09-01-91	12-29-91
ST91-10482	ANR Pipeline Co.....	Stellar Gas Co.....	09-23-91	G-S	50,000	N	I	09-01-91	12-29-91
ST91-10483	ANR Pipeline Co.....	Northern States Power Co Wisconsin.	09-23-91	B	35,622	N	I	09-01-91	Indef.
ST91-10484	ANR Pipeline Co.....	S. Indiana Gas & Electric Co.	09-23-91	B	100,000	N	I	09-02-91	Indef.
ST91-10485	ANR Pipeline Co.....	Northern Illinois Gas Co....	09-23-91	B	100,000	N	I	09-05-91	Indef.
ST91-10486	Panhandle Eastern Pipe Line Co.	Enron Gas Marketing, Inc.	09-23-91	G-S	50,000	N	I	09-01-91	12-30-91
ST91-10487	Panhandle Eastern Pipe Line Co.	Seward County Gas Co....	09-23-91	B	150	N	I	09-01-91	Indef.
ST91-10488	Panhandle Eastern Pipe Line Co.	Coastal Gas Marketing Co.	09-23-91	G-S	100,000	N	I	09-01-91	12-30-91
ST91-10489	Northwest Pipeline Corp...	El Paso Natural Gas Co....	09-23-91	B	16,000	N	I	07-01-91	Indef.
ST91-10490	Florida Gas Transmission Co.	Peoples Gas System, Inc.	09-23-91	B	4,395	N	I	09-01-91	Indef.
ST91-10491	Transcontinental Gas P/L Corp.	Mitchell Marketing Co.....	09-23-91	B	50,000	N	I	09-07-91	Indef.
ST91-10492	Transcontinental Gas P/L Corp.	Transco Energy Marketing Co.	09-23-91	G-S	2,500,000	N	I	08-01-91	11-28-91
ST91-10493	United Gas Pipe Line Co...	Stellar Gas Co.....	09-23-91	G-S	524,000	N	I	08-22-91	12-20-91
ST91-10494	United Gas Pipe Line Co...	American Pipeline Co.....	09-23-91	G-S	1,572	N	I	09-10-91	01-08-92
ST91-10495	United Gas Pipe Line Co...	Mobil Natural Gas Inc.....	09-23-91	G-S	52,400	N	I	08-23-91	12-21-91
ST91-10496	United Gas Pipe Line Co...	Centran Corp.....	09-23-91	G-S	20,960	N	I	09-10-91	01-08-92
ST91-10497	United Gas Pipe Line Co...	Aikla Energy Marketing Co.	09-23-91	G-S	209,600	N	I	09-10-91	01-08-92
ST91-10498	United Gas Pipe Line Co...	Equitable Resources Marketing Co.	09-23-91	G-S	262,000	N	I	09-10-91	01-08-92
ST91-10499	United Gas Pipe Line Co...	Pennzoil Gas Marketing Co.	09-23-91	G-S	209,600	N	I	07-19-91	11-16-91
ST91-10500	Delhi Gas Pipeline Corp....	Transwestern Pipeline Co.	09-24-91	C	2,000	N	I	09-01-91	Indef.
ST91-10501	Delhi Gas Pipeline Corp....	Panhandle Eastern Pipeline Co.	09-24-91	C	5,000	N	I	09-01-91	Indef.
ST91-10502	Delhi Gas Pipeline Corp....	Panhandle Eastern Pipeline Co.	09-24-91	C	5,000	N	I	09-03-91	Indef.
ST91-10503	Red River Pipeline.....	El Paso Natural Gas Co....	09-24-91	C	50,000	N	I	09-07-91	Indef.
ST91-10504	El Paso Natural Gas Co...	Valero Industrial Gas, L.P.	09-24-91	G-S	206,000	N	I	09-06-91	01-04-92
ST91-10505	ANR Pipeline Co.....	Interstate Gas Marketing, Inc.	09-24-91	G-S	240,000	N	I	08-14-91	09-01-91

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ST91-10506	ANR Pipeline Co.....	Triumph Gas Marketing Co.	09-24-91	G-S	10,000	N	I	09-01-91	12-29-91
ST91-10507	Colorado Interstate Gas Co.	Western Gas Processors, Ltd.	09-24-91	G-S	50,000	N	I	08-17-91	12-15-91
ST91-10508	Northwest Pipeline Corp...	El Paso Natural Gas Co....	09-24-91	B	15,000	N	F	07-01-91	01-01-92
ST91-10509	United Gas Pipe Line Co...	Coastal Gas Marketing Co.	09-24-91	G-S	52,400	N	I	09-01-91	12-30-91
ST91-10510	United Gas Pipe Line Co...	Enron Gas Marketing, Inc.	09-24-91	G-S	524,000	N	I	08-29-91	12-27-91
ST91-10511	United Gas Pipe Line Co...	Arkla Energy Marketing Co.	09-24-91	G-S	209,600	N	F	09-11-91	01-09-92
ST91-10512	Enogex Inc.....	Panhandle Eastern Pipeline Co.	09-24-91	C	50,000	N	I	09-06-91	Indef.
ST91-10513	Arkla Energy Resources...	Arkla Energy Marketing Co.	09-24-91	G-S	40,000	Y	I	09-12-91	01-11-92
ST91-10514	Columbia Gulf Transmission Co.	Eagle Natural Gas Co.....	09-24-91	G-S	30,000	N	I	09-02-91	12-30-91
ST91-10515	Columbia Gulf Transmission Co.	NGC Transportation, Inc....	09-24-91	G-S	200,000	N	I	09-01-91	12-29-91
ST91-10516	Columbia Gulf Transmission Co.	Atlas Gas Marketing, Inc..	09-24-91	G-S	10,000	N	I	09-15-91	01-12-92
ST91-10517	Columbia Gulf Transmission Co.	Amerada Hess Corp.....	09-24-91	G-S	100,000	N	I	09-14-91	01-11-92
ST91-10518	Transcontinental Gas P/L Corp.	Entlade Corp.....	09-24-91	G-S	500,000	N	I	09-01-91	07-31-92
ST91-10519	Transcontinental Gas P/L Corp.	Marathon Oil Co.....	09-24-91	G-S	130,000	N	I	09-01-91	09-30-91
ST91-10520	Transcontinental Gas P/L Corp.	CNG Transmission Corp...	09-24-91	B	36,364	N	F	09-02-91	07-31-06
ST91-10521	Transcontinental Gas P/L Corp.	Public Service Electric & Gas Co.	09-24-91	B	361,527	Y	F	04-01-91	10-31-05
ST91-10522	Tennessee Gas Pipeline Co.	Coast Energy Group.....	09-25-91	G-S	50,000	N	I	08-17-91	12-15-91
ST91-10523	Tennessee Gas Pipeline Co.	NGC Transportation, Inc....	09-25-91	G-S	700,000	N	I	09-23-91	01-21-92
ST91-10524	Panhandle Eastern Pipe Line Co.	Amgas, Inc.....	09-25-91	G-S	100	N	I	09-01-91	12-30-91
ST91-10525	Panhandle Eastern Pipe Line Co.	Union Electric Co.....	09-25-91	B	400	N	I	09-01-91	10-01-91
ST91-10526	Panhandle Eastern Pipe Line Co.	Amgas, Inc.....	09-25-91	G-S	20	N	I	09-01-91	12-30-91
ST91-10527	Panhandle Eastern Pipe Line Co.	Amgas, Inc.....	09-25-91	G-S	80	N	I	09-01-91	12-30-91
ST91-10528	Panhandle Eastern Pipe Line Co.	Unigas Energy, Inc.....	09-25-91	G-S	100,000	N	I	09-01-91	12-30-91
ST91-10529	Panhandle Eastern Pipe Line Co.	Amgas, Inc.....	09-25-91	G-S	500	N	F	09-01-91	12-30-91
ST91-10530	Panhandle Eastern Pipe Line Co.	Wellsville Fire Brick Co....	09-25-91	G-S	500	N	F	09-01-91	12-30-91
ST91-10531	Panhandle Eastern Pipe Line Co.	Amgas, Inc.....	09-25-91	G-S	45	N	F	09-01-91	12-30-91
ST91-10532	Panhandle Eastern Pipe Line Co.	Amgas, Inc.....	09-25-91	G-S	300	N	F	09-01-91	12-30-91
ST91-10533	Panhandle Eastern Pipe Line Co.	Amgas, Inc.....	09-25-91	G-S	70	N	F	09-01-91	12-30-91
ST91-10534	Panhandle Eastern Pipe Line Co.	Amgas, Inc.....	09-25-91	G-S	200	N	F	09-01-91	12-30-91
ST91-10535	Panhandle Eastern Pipe Line Co.	Amoco Energy Trading Corp.	09-25-91	G-S	3,000	N	I	09-01-91	12-30-91
ST91-10536	Columbia Gulf Transmission Co.	Unocal Exploration Corp...	09-25-91	G-S	60,000	N	I	09-01-91	12-29-91
ST91-10537	CNG Transmission Corp...	Indeck Energy Services....	09-25-91	G-S	6,350	N	F	09-01-91	01-29-92
ST91-10538	Natural Gas P/L Co. of America.	Hadson Gas System, Inc..	09-25-91	G-S	150,000	N	I	08-27-91	12-25-91
ST91-10539	United Gas Pipe Line Co...	OXY USA Inc.....	09-26-91	G-S	23,056	N	I	09-13-91	01-11-92
ST91-10540	United Gas Pipe Line Co...	Enron Gas Marketing, Inc.	09-26-91	G-S	524,000	N	I	09-16-91	01-14-92
ST91-10541	United Gas Pipe Line Co...	NGC Transportation, Inc. Inc.	09-26-91	G-S	157,200	N	I	09-18-91	01-16-92
ST91-10542	Transcontinental Gas P/L Corp.	Consolidated Edison Co. of NY, Inc.	09-26-91	B	210,665	N	F	04-01-91	03-31-05
ST91-10543	Sea Robin Pipeline Co.....	Oryx Gas Marketing L.P....	09-26-91	G-S	100,000	N	I	09-04-91	01-02-92
ST91-10544	Sea Robin Pipeline Co.....	Columbia Gas Development.	09-26-91	G-S	50,000	N	I	09-05-91	01-03-92
ST91-10545	Sea Robin Pipeline Co.....	O & R Energy, Inc.....	09-26-91	G-S	50,000	N	I	09-01-91	12-30-91
ST91-10546	Southern Natural Gas Co.	Eastex Hydrocarbons, Inc.	09-26-91	G-S	50,000	N	I	08-31-91	12-29-91
ST91-10547	El Paso Natural Gas Co....	Hadson Gas Systems, Inc.	09-27-91	G-S	10,000	N	I	09-11-91	09-04-92

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ST91-10548	El Paso Natural Gas Co....	American Central Gas Cos., Inc.	09-27-91	G-S	50,000	N	I	09-01-91	08-29-92
ST91-10549	El Paso Natural Gas Co....	Landmark Gas Corp.....	09-27-91	G-S	2,060	N	I	09-02-91	05-24-92
*ST91-10550	Arkla Energy Resources....	Standard Gas Marketing Co.	09-27-91	G-S	10,000	N	F	10-01-91	Indef.
ST91-10551	ONG Transmission Co.....	Phillips Gas Pipeline Co....	09-27-91	C	100,000	N	I	09-01-91	Indef.
ST91-10552	ONG Transmission Co.....	Northern Natural Gas Co....	09-27-91	C	1,000	N	I	09-01-91	Indef.
ST91-10553	Natural Gas P/L Co. of America.	Valero Transmission, L.P..	09-27-91	B	150,000	N	I	08-30-91	Indef.
ST91-10554	Natural Gas P/L Co. of America.	Anthem Energy Co.....	09-27-91	G-S	50,000	N	I	09-01-91	12-30-91
ST91-10555	Natural Gas P/L Co. of America.	Reynolds Pipeline Systems, Inc.	09-27-91	G-S	4,000	N	F	09-01-91	12-30-91
ST91-10556	Natural Gas P/L Co. of America.	Midcon Marketing Corp.....	09-27-91	G-S	100,000	N	I	09-01-91	12-30-91
ST91-10557	Natural Gas P/L Co. of America.	Polaris Corp.....	09-27-91	G-S	500,000	N	I	09-01-91	12-30-91
ST91-10558	Williston Basin Inter. P/L Co.	Aquila Energy Marketing Corp.	09-27-91	G-S	277,000	N	I	09-01-91	08-31-93
ST91-10559	Williston Basin Inter. P/L Co.	South Dakota State Cement Plant.	09-27-91	B	438	N	F	09-01-91	08-31-92
ST91-10560	Williston Basin Inter. P/L Co.	Western Gas Resources, Inc.	09-27-91	G-S	212,740	N	I	09-01-91	08-31-93
ST91-10561	Williston Basin Inter. P/L Co.	Rainbow Gas Co.....	09-27-91	G-S	89,751	N	I	08-29-91	08-31-92
ST91-10562	Tennessee Gas Pipeline Co.	Valley Gas Co.....	09-27-91	B	500,000	N	I	09-24-91	Indef.
ST91-10563	Tennessee Gas Pipeline Co.	Commonwealth Gas Co....	09-27-91	B	500,000	N	I	09-24-91	Indef.
ST91-10564	Tennessee Gas Pipeline Co.	Pennsylvania Gas & Water Co.	09-27-91	B	500,000	N	I	09-24-91	Indef.
ST91-10565	Tennessee Gas Pipeline Co.	Consolidated Edison Co. NY, Inc.	09-27-91	B	500,000	N	I	09-24-91	Indef.
ST91-10566	Tennessee Gas Pipeline Co.	Centran Corp.....	09-27-91	G-S	18,974	N	I	09-01-89	12-30-89
ST91-10567	Tennessee Gas Pipeline Co.	Access Energy Corp.....	09-27-91	G-S	500,000	N	I	09-24-91	01-22-92
ST91-10568	Tennessee Gas Pipeline Co.	Equitable Gas Co.....	09-27-91	B	500,000	N	I	09-24-91	Indef.
ST91-10569	Tennessee Gas Pipeline Co.	Southern Connecticut Gas Co.	09-27-91	B	500,000	N	I	09-24-91	Indef.
ST91-10570	Panhandle Eastern Pipe Line Co.	Angas, Inc.....	09-27-91	G-S	100	N	F	09-01-91	12-30-91
ST91-10571	Panhandle Eastern Pipe Line Co.	A. E. Staley Manufacturing Co.	09-27-91	G-S	3,000	N	F	09-01-91	12-30-91
ST91-10572	Panhandle Eastern Pipe Line Co.	Village of Pawnee.....	09-27-91	B	1,550	N	I	09-01-91	12-30-91
ST91-10573	Panhandle Eastern Pipe Line Co.	Village of Divernon.....	09-27-91	G-S	1,050	N	I	09-09-91	01-07-92
ST91-10574	Panhandle Eastern Pipe Line Co.	Appalachian Gas Sales.....	09-27-91	G-S	2,500	N	I	09-01-91	12-30-91
ST91-10575	Panhandle Eastern Pipe Line Co.	Village of Riverton.....	09-27-91	G-S	1,650	N	I	09-09-91	01-07-92
ST91-10576	Panhandle Eastern Pipe Line Co.	CNG Producing Co.....	09-27-91	G-S	20,000	N	I	09-01-91	12-30-91
ST91-10577	Panhandle Eastern Pipe Line Co.	Cabot Oil & Gas Marketing Corp.	09-27-91	G-S	20,000	N	I	09-01-91	12-30-91
ST91-10578	Questar Pipeline Co.....	Nephi City Corp.....	09-26-91	B	2,000	N	I	09-18-91	09-18-92
ST91-10579	K N Energy, Inc.....	Hastings Utilities.....	09-26-91	G-S	20,000	N	F/I	09-01-91	12-29-91
ST91-10580	K N Energy, Inc.....	Hastings Utilities.....	09-26-91	G-S	20,000	N	I	09-01-91	12-29-91
ST91-10581	K N Energy, Inc.....	K N Gas Marketing, Inc....	09-26-91	G-S	150,000	N	I	09-01-91	12-29-91
ST91-10582	Tennessee Gas Pipeline Co.	Seagull Marketing Services, Inc.	09-26-91	G-S	250,000	N	I	08-01-91	11-29-91
ST91-10583	Tennessee Gas Pipeline Co.	Energy Marketing Exchange, Inc.	09-26-91	G-S	7,000	N	I	09-01-91	12-30-91
ST91-10584	ONG Transmission Co.....	ANR Pipeline Co.....	09-26-91	C	1,000	N	I	08-27-91	Indef.
ST91-10585	Natural Gas P/L Co. of America.	Arcadian Corp.....	09-26-91	G-S	50,000	N	I	08-30-91	12-28-91
ST91-10586	Natural Gas P/L Co. of America.	Arcadian Corp.....	09-26-91	G-S	45,000	N	F	09-01-91	12-30-91
ST91-10587	Panhandle Eastern Pipe Line Co.	City of Auburn.....	09-27-91	G-S	2,100	N	I	09-01-91	12-30-91
ST91-10588	Panhandle Eastern Pipe Line Co.	City of White Hall.....	09-27-91	G-S	2,200	N	I	09-12-91	01-10-92
ST91-10589	Panhandle Eastern Pipe Line Co.	Utilicorp United, Inc.....	09-27-91	G-S	15,000	N	I	09-10-91	01-08-92
ST91-10590	Panhandle Eastern Pipe Line Co.	Appalachian Gas Sales.....	09-27-91	G-S	1,500	N	I	09-01-91	12-30-91
ST91-10591	Panhandle Eastern Pipe Line Co.	City of Roodhouse.....	09-27-91	G-S	1,525	N	I	09-12-91	01-10-92

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ST91-10592	Panhandle Eastern Pipe Line Co.	City of Winchester	09-27-91	G-S	1,450	N	I	09-12-91	12-30-91
ST91-10593	Panhandle Eastern Pipe Line Co.	Amgas, Inc.....	09-27-91	G-S	130	N	I	09-01-91	12-30-91
ST91-10594	United Gas Pipe Line Co.	Ledco Inc.....	09-27-91	G-S	488,629	N	I	09-16-91	01-14-91
ST91-10595	United Gas Pipe Line Co.	Associated Intrastate Pipeline Co.	09-27-91	G-S	209,600	N	I	09-12-91	01-10-92
ST91-10596	Valero Transmission, L.P.	United Gas Pipe Line Co.	09-27-91	C	6,100	N	I	09-01-91	Indef.
ST91-10597	Arkla Energy Resources	Union Natural Gas Co.	09-27-91	G-S	1,000	N	F	09-01-91	12-29-91
ST91-10598	Arkla Energy Resources	Delhi Gas Pipeline Corp.	09-27-91	B	150,000	N	I	09-01-91	Indef.
ST91-10599	Panhandle Eastern Pipe Line Co.	Amgas, Inc.....	09-27-91	G-S	600	N	I	09-01-91	12-30-91
ST91-10600	Panhandle Eastern Pipe Line Co.	Amgas, Inc.....	09-27-91	G-S	80	N	I	09-01-91	12-30-91
ST91-10601	Florida Gas Transmission Co.	Endevco Oil and Gas Co.	09-27-91	G-S	50,000	N	I	09-05-91	01-01-92
ST91-10602	Northern Natural Gas Co.	Teco Gas Marketing Co.	09-27-91	G-S	150,000	N	F/I	09-10-91	01-08-92
ST91-10603	Northern Natural Gas Co.	Centran Corp.....	09-27-91	G-S	15,000	N	F/I	09-07-91	01-06-92
ST91-10604	Delhi Gas Pipeline Corp.	Panhandle Eastern Pipeline Co.	09-30-91	C	10,000	N	I	09-01-91	Indef.
ST91-10605	Delhi Gas Pipeline Corp.	Arkla Energy Resources	09-30-91	C	30,000	N	I	09-02-91	Indef.
ST91-10606	Delhi Gas Pipeline Corp.	United Gas Pipeline Co.	09-30-91	C	10,000	N	I	09-01-91	Indef.
ST91-10607	Lone Star Gas Co.	El Paso Natural Gas Co.	09-30-91	C	100,000	N	I	06-21-91	Indef.
ST91-10608	Valero Transmission, L.P.	Natural Gas P/L Co. of America.	09-30-91	C	1,550	N	I	09-01-91	Indef.
ST91-10609	Northern Natural Gas Co.	Cibola Corp.....	09-30-91	G-S	100,000	N	F/I	09-01-91	12-30-91
ST91-10610	Natural Gas P/L Co. of America.	Vesta Energy Co.....	09-30-91	G-S	10,000	N	I	09-01-91	12-30-91
ST91-10611	Natural Gas P/L Co. of America.	North Canadian Marketing Corp.	09-30-91	G-S	150,000	N	I	09-01-91	12-30-91
ST91-10612	Natural Gas P/L Co. of America.	Nipsco Energy Trading Co.	09-30-91	G-S	25,000	N	I	09-01-91	12-30-91
ST91-10613	Natural Gas P/L Co. of America.	Centennial Natural Gas Corp.	09-30-91	G-S	300,000	N	I	09-01-91	12-30-91
ST91-10614	Mississippi River Trans. Corp.	Louisiana Intrastate Gas Corp.	09-30-91	B	25,000	Y	F	09-01-91	Indef.
ST91-10615	Mississippi River Trans. Corp.	Entrade Corp.....	09-30-91	G-S	50,000	N	I	09-07-91	01-05-92
ST91-10616	Mississippi River Trans. Corp.	City of Red Bud.....	09-30-91	G-S	810	N	F	09-16-91	01-14-92
ST91-10617	Mississippi River Trans. Corp.	Arkla Energy Marketing Co.	09-30-91	G-S	350	N	F	09-01-91	12-30-91
ST91-10618	Transcontinental Gas P/L Corp.	End Users Supply System, Inc.	09-30-91	G-S	40,000	N	I	09-03-91	12-31-91
ST91-10619	Transcontinental Gas P/L Corp.	East Central Alabama Gas District.	09-30-91	B	1,352	N	F	04-01-91	12-31-91
ST91-10620	Trunkline Gas Co.	Texaco Gas Marketing, Inc.	09-30-91	G-S	25,000	N	I	08-27-91	12-25-91
ST91-10621	Trunkline Gas Co.	Chevron U.S.A. Inc.....	09-30-91	G-S	50,000	N	I	08-30-91	12-28-91
ST91-10622	Trunkline Gas Co.	CNG Producing Co.....	09-30-91	G-S	20,000	N	I	09-01-91	12-30-91
ST91-10623	Trunkline Gas Co.	Natural Gas Clearinghouse, Inc.	09-30-91	G-S	50,000	N	I	09-01-91	12-30-91
ST91-10624	Trunkline Gas Co.	Enermax, Division of Nukem, Inc.	09-30-91	G-S	100,000	N	I	09-01-91	12-30-91
ST91-10625	Trunkline Gas Co.	Enermax, Division of Nukem, Inc.	09-30-91	G-S	50,000	N	I	09-01-91	12-30-91
ST91-10626	Panhandle Eastern Pipe Line Co.	City of Gruver.....	09-30-91	G-S	1,000	N	I	09-01-91	12-30-91
ST91-10627	Tennessee Gas Pipeline Co.	Energy Marketing Exchange, Inc.	09-30-91	G-S	200,000	N	I	09-23-91	01-21-91
ST91-10628	Tennessee Gas Pipeline Co.	Mobil Natural Gas, Inc.	09-30-91	G-S	100,000	N	I	09-01-91	12-30-91
ST91-10629	Tennessee Gas Pipeline Co.	Mobil Natural Gas, Inc.	09-30-91	G-S	100,000	N	I	08-28-91	12-26-91
ST91-10630	Tennessee Gas Pipeline Co.	Transco Gas Pipeline Co.	09-30-91	G-S	225,000	N	I	09-01-91	12-30-91

¹ Transportation service converted from authority under 18 CFR 284.106, subpart B, to authority under 18 CFR 284.223(F)(1), subpart G-S.

² Notice of transactions does not constitute a determination that filings comply with commission regulations in accordance with order no. 436 (final rule and notice requesting supplemental comments, 50 FR 42,372, 10/10/85).

Estimated maximum daily volumes includes volumes reported by the filing company in MMBTU, MCF and DT.

[FR Doc. 91-28186 Filed 11-22-91; 8:45 am]

BILLING CODE 6717-01-M

[Docket Nos. ST92-0001-000 Through ST92-0436-000]

Panhandle Eastern Pipe Line Co.; Self-Implementing Transactions

November 18, 1991.

Take notice that the following transactions have been reported to the Commission as being implemented pursuant to part 284 of the Commission's regulations, sections 311 and 312 of the Natural Gas Policy Act of 1978 (NGPA) and section 5 of the Outer Continental Shelf Lands Act.¹

The "Recipient" column in the following table indicates the entity receiving or purchasing the natural gas in each transaction.

The "part 284 subpart" column in the following table indicates the type of transaction.

A "B" indicates transportation by an interstate pipeline on behalf of an intrastate pipeline or a local distribution company pursuant to § 284.102 of the

Commission's regulations and section 311(a)(1) of the NGPA.

A "C" indicates transportation by an intrastate pipeline on behalf of an interstate pipeline or a local distribution company served by an interstate pipeline pursuant to § 284.122 of the Commission's regulations and section 311(a)(2) of the NGPA.

A "D" indicates a sale by an intrastate pipeline to an interstate pipeline or a local distribution company served by an interstate pipeline pursuant to § 284.142 of the Commission's Regulations and section 311(b) of the NGPA. Any interested person may file a complaint concerning such sales pursuant to § 284.147(d) of the Commission's Regulations.

An "E" indicates an assignment by an intrastate pipeline to any interstate pipeline or local distribution company pursuant to § 284.163 of the Commission's regulations and section 312 of the NGPA.

A "G" indicates transportation by an interstate pipeline on behalf of another interstate pipeline pursuant to § 284.222 and a blanket certificate issued under § 284.221 of the Commission's regulations.

A "G-S" indicates transportation by interstate pipelines on behalf of shippers

other than interstate pipelines pursuant to § 284.223 and a blanket certificate issued under § 284.221 of the Commission's regulations.

A "G-LT" or "G-LS" indicates transportation, sales or assignments by a local distribution company on behalf of or to an interstate pipeline or local distribution company pursuant to a blanket certificate issued under § 284.224 of the Commission's regulations.

A "G-HT" or "G-HS" indicates transportation, sales or assignments by a Hinshaw Pipeline pursuant to a blanket certificate issued under § 284.224 of the Commission's regulations.

A "K" indicates transportation of natural gas on the Outer Continental Shelf by an interstate pipeline on behalf of another interstate pipeline pursuant to § 284.303 of the Commission's regulations.

A "K-S" indicates transportation of natural gas on the Outer Continental Shelf by an intrastate pipeline on behalf of shippers other than interstate pipelines pursuant to § 284.303 of the Commission's regulations.

Lois D. Cashell,
Secretary.

¹ Notice of a transaction does not constitute a determination that the terms and conditions of the proposed service will be approved or that the noticed filing is in compliance with the Commission's regulations.

Docket No. ¹	Transporter/seller	Recipient	Date filed	Part 284 subpart	Est. max. daily quantity ²	Aff. Y/N	Rate schedule	Date commenced	Projected termination date
ST92-0001	Panhandle Eastern Pipe Line Co.	Enermax, Div. of Nukem, Inc.	10-01-91	G-S	30,000	N	I	09-02-91	12-31-91
ST92-0002	Florida Gas Transmission Co.	City of Lakeland	10-01-91	G-S	19,000	N	F	09-18-91	01-25-91
ST92-0003	ANR Pipeline Co.	TPC Pipeline, Inc.	10-01-91	B	100,000	N	I	09-06-91	Indef.
ST92-0004	Colorado Interstate Gas Co.	Texaco Gas Marketing, Inc.	10-01-91	G-S	100,000	N	I	09-01-91	12-30-91
ST92-0005	Colorado Interstate Gas Co.	Westar Marketing Co.	10-01-91	G-S	25,000	N	I	09-01-91	12-30-91
ST92-0006	Trailblazer Pipeline Co.	Enron Marketing, Inc.	10-01-91	G-S	35,000	N	F	09-01-91	12-30-91
ST92-0007	Stingray Pipeline Co.	Nortech Energy Corp.	10-01-91	K-S	15,000	N	I	09-30-91	12-30-91
ST92-0008	Stingray Pipeline Co.	Olympic Fuels Co.	10-01-91	K-S	50,000	N	I	09-30-91	12-30-91
ST92-0009	Natural Gas P/L Co. of America.	Island Steel Co.	10-01-91	G-S	10,000	N	F	09-01-91	12-30-91
ST92-0010	Natural Gas P/L Co. of America.	Quantum Chemical Corp.	10-01-91	G-S	9,600	N	F	09-01-91	12-30-91
ST92-0011	Natural Gas P/L Co. of America.	North Canadian Marketing.	10-01-91	B	150,000	N	I	09-01-91	Indef.
ST92-0012	Natural Gas P/L Co. of America.	Southern California Gas Co.	10-01-91	B	200,000	N	I	09-01-91	Indef.
ST92-0013	Great Lakes Gas Trans. L.P.	Triumph Gas Marketing	10-01-91	G-S	200,000	N	I	09-01-91	12-29-91
ST92-0014	Louisiana Resources Co.	Texas Gas Transmission Corp.	10-01-91	C	200,000	N	I	09-27-91	Indef.
ST92-0015	Louisiana Resources Co.	Tennessee Gas Pipeline Co.	10-01-91	C	200,000	N	I	09-27-91	Indef.
ST92-0016	Louisiana Resources Co.	ANR Pipeline Co.	10-01-91	C	200,000	N	I	09-27-91	Indef.
ST92-0017	Louisiana Resources Co.	Trunkline Gas Co.	10-01-91	C	200,000	N	I	09-27-91	Indef.
ST92-0018	Louisiana Resources Co.	United Gas Pipe Line Co.	10-01-91	C	200,000	N	I	09-27-91	Indef.
ST92-0019	Louisiana Resources Co.	Southern Natural Gas Marketing Co.	10-01-91	C	200,000	N	I	09-27-91	Indef.
ST92-0020	Louisiana Resources Co.	Transcontinental Gas P/L Corp.	10-01-91	C	200,000	N	I	09-27-91	Indef.
ST92-0021	Louisiana Resources Co.	Stingray Pipeline Co.	10-01-91	C	200,000	N	I	09-27-91	Indef.

Docket No. ¹	Transporter/seller	Recipient	Date filed	Part 284 subpart	Est. max. daily quantity ²	Aff. Y/N	Rate schedule	Date commenced	Projected termination date
ST92-0022	Louisiana Resources Co...	Columbia Gulf Transmission Co.	10-01-91	C	200,000	N	I	09-27-91	Indef.
ST92-0023	Louisiana Resources Co...	Sabine Pipe Line Co.	10-01-91	C	200,000	N	I	09-27-91	Indef.
ST92-0024	Louisiana Resources Co...	Stingray Pipeline Co.	10-01-91	C	50,000	N	I	09-27-91	Indef.
ST92-0025	Louisiana Resources Co...	Texas Eastern Transmission Co.	10-01-91	C	200,000	N	I	09-27-91	Indef.
ST92-0026	Louisiana Resources Co...	Sea Robin Pipeline Co.	10-01-91	C	200,000	N	I	09-27-91	Indef.
ST92-0027	Williams Natural Gas Co...	Cibola Corp.	10-01-91	G-S	42,300	N	I	09-01-91	12-29-91
ST92-0028	Williams Natural Gas Co...	Tenaska Marketing Ventures.	10-01-91	G-S	125,000	N	I	09-01-91	12-29-91
ST92-0029	Transok, Inc.	Phillips Gas Pipeline Co.	10-01-91	C	2,000	N	I	09-01-91	Indef.
ST92-0030	Western Transmission Corp.	ANR Pipeline Co.	10-01-91	G	1,000	N	I	06-01-91	Indef.
ST92-0031	Arkla Energy Resources	Louisiana Intrastate Gas Corp.	10-01-91	B	25,000	Y	F	09-01-91	11-01-92
ST92-0032	Arkla Energy Resources	Chevron U.S.A., Inc.	10-01-91	G-S	15,000	N	I	08-12-91	12-11-91
ST92-0033	Tennessee Gas Pipeline Co.	Atlas Gas Marketing, Inc.	10-01-91	G-S	20,000	N	I	09-05-91	01-03-92
ST92-0034	Tennessee Gas Pipeline Co.	CNG Transmission Corp.	10-01-91	B	250,000	Y	I	09-30-91	Indef.
ST92-0035	Tennessee Gas Pipeline Co.	Bishop Pipeline Corp.	10-01-91	G-S	50,000	N	I	09-01-91	12-30-91
ST92-0036	Tennessee Gas Pipeline Co.	Catamount Natural Gas, Inc.	10-01-91	G-S	102,600	N	I	09-01-91	12-30-91
ST92-0037	Tennessee Gas Pipeline Co.	Tejas Hydrocarbon Co.	10-01-91	G-S	125,600	N	I	09-01-91	12-30-91
ST92-0038	Tennessee Gas Pipeline Co.	Meridian Oil Inc.	10-01-91	G-S	200,000	N	I	09-01-91	12-30-91
ST92-0039	Tennessee Gas Pipeline Co.	Catamount Natural Gas, Inc.	10-01-91	G-S	20,000	N	I	09-02-91	12-31-91
ST92-0040	Tennessee Gas Pipeline Co.	Conoco, Inc.	10-01-91	G-S	696,488	N	I	09-08-91	01-06-92
ST92-0041	Tennessee Gas Pipeline Co.	Coastal Gas Marketing Co.	10-01-91	G-S	300,000	N	I	09-01-91	12-30-91
ST92-0042	Tennessee Gas Pipeline Co.	Chevron U.S.A., Inc.	10-01-91	G-S	450,000	N	I	09-01-91	12-30-91
ST92-0043	Tennessee Gas Pipeline Co.	Columbia Gas Development Corp.	10-01-91	G-S	50,000	N	I	09-02-91	12-31-91
ST92-0044	Tennessee Gas Pipeline Co.	Mississippi Fuel Co.	10-01-91	B	1,000	N	F	09-01-91	Indef.
ST92-0045	Tennessee Gas Pipeline Co.	Conoco Inc.	10-01-91	G-S	212,175	N	I	09-01-91	12-30-91
ST92-0046	Trunkline Gas Co.	Stellar Gas Co.	10-02-91	G-S	20,000	N	I	09-04-91	01-02-92
ST92-0047	Trunkline Gas Co.	Peoples Gas Light and Coke Co.	10-02-91	B	20,000	N	I	09-06-91	Indef.
ST92-0048	Trunkline Gas Co.	Mega Natural Gas Co.	10-02-91	G-S	100,000	N	I	09-06-91	01-04-92
ST92-0049	Trunkline Gas Co.	Hadson Gas Systems, Inc.	10-02-91	G-S	75,000	N	I	09-06-91	01-04-92
ST92-0050	Trunkline Gas Co.	Louisiana Intrastate Gas Corp.	10-02-91	B	100,000	N	I	09-05-91	Indef.
ST92-0051	Trunkline Gas Co.	Exxon Corp.	10-02-91	G-S	25,000	N	I	09-10-91	01-08-92
ST92-0054	Northern Natural Gas Co.	Peoples Natural Gas Co.	10-03-91	B	50,000	N	F/I	11-30-90	Indef.
ST92-0055	Overthrust Pipeline Co.	Chevron U.S.A., Inc.	10-04-91	G-S	40,000	N	I	10-01-91	01-28-91
ST92-0056	Traillblazer Pipeline Co.	Vesgas Co.	10-04-91	G-S	5,000	N	I	09-01-91	12-30-91
ST92-0057	Enogex Inc.	Arkla Energy Resources	10-03-91	C	150,000	N	I	09-01-91	Indef.
ST92-0058	Enogex Inc.	Arkla Energy Resources	10-03-91	C	60,000	N	I	09-01-91	Indef.
ST92-0059	Enogex Inc.	Phillips Gas Pipeline Co.	10-03-91	C	100,000	N	I	09-01-91	Indef.
ST92-0060	Tennessee Gas Pipeline Co.	Citizens Gas Supply Corp.	10-03-91	G-S	10,000	N	F	09-01-91	11-01-91
ST92-0061	Midwestern Gas Transmission Co.	Texpar Energy, Inc.	10-03-91	G-S	50,000	N	I	09-10-91	01-08-92
ST92-0062	United Gas Pipe Line Co.	Riverway Gas Pipeline Co.	10-03-91	G-S	209,600	N	I	09-18-91	01-16-92
ST92-0063	United Gas Pipe Line Co.	Ashton Energy, Inc.	10-03-91	G-S	20,960	N	I	09-20-91	01-18-92
ST92-0064	United Gas Pipe Line Co.	Arcadian Corp.	10-03-91	G-S	57,640	N	F	09-24-91	01-22-92
ST92-0065	United Gas Pipe Line Co.	Graham Energy Marketing Corp.	10-03-91	G-S	125,760	N	I	09-25-91	01-23-92
ST92-0066	United Gas Pipe Line Co.	Laser Marketing Co.	10-03-91	G-S	628,800	N	I	09-19-91	01-17-92
ST92-0067	Gas Company of New Mexico.	El Paso Natural Gas Co.	10-04-91	G-HT	4,000	N	I	09-01-91	08-31-93
ST92-0068	Gas Company of New Mexico.	El Paso Natural Gas Co.	10-04-91	G-HT	8,000	N	F	09-01-91	11-30-92
ST92-0069	Gas Company Gas of New Mexico.	El Paso Natural Gas Co.	10-04-91	G-HT	3,000	N	I	09-01-91	08-31-92
ST92-0070	Transcontinental Gas P/L Corp.	Washington Gas Light Co.	10-04-91	B	50,000	N	I	09-26-91	Indef.
ST92-0071	Columbia Gas Transmission Corp.	Endevco, Inc.	10-04-91	G-S	60,000	Y	I	09-26-91	01-24-92
ST92-0072	Williston Basin Inter. P/L Co.	Prairie Lands Energy Marketing, Inc.	10-04-91	G-S	32,000	Y	I	09-06-91	10-14-92

Docket No. ¹	Transporter/seller	Recipient	Date filed	Part 284 subpart	Est. max. daily quantity ²	Aff. Y/N	Rate schedule	Date commenced	Projected termination date
ST92-0073	National Fuel Gas Supply Corp.	Snap-Tite, Inc.	10-04-91	B	75	N	I	09-01-91	08-31-11.
ST92-0074	Transok, Inc.	Arkla Energy Resources, Co.	10-07-91	C	50,000	N	I	09-06-91	Indef.
ST92-0075	Northern Natural Gas Co.	Panda Resources, Inc.	10-07-91	G-S	100,000	N	F/I	09-04-91	01-02-92.
ST92-0076	Florida Gas Transmission Co.	West Florida Natural Gas Co.	10-07-91	G-S	4,187	N	F	10-01-91	01-28-92.
ST92-0077	Florida Gas Transmission Co.	Procter & Gamble Cellulose Co.	10-07-91	G-S	995	N	F	10-01-91	01-28-92.
ST92-0078	Houston Pipe Line Co.	Texas Eastern Transmission Corp.	10-07-91	C	50,000	N	I	08-21-91	Indef.
ST92-0079	Houston Pipe Line Co.	Transcontinental Gas P/L Corp.	10-07-91	C	36,000	N	I	07-01-91	Indef.
ST92-0080	Houston Pipe Line Co.	Phillips Gas Pipeline Co.	10-07-91	C	50,000	N	I	08-06-91	Indef.
ST92-0081	Houston Pipe Line Co.	Florida Gas Transmission Co.	10-07-91	C	100,000	N	I	08-03-91	Indef.
ST92-0082	Houston Pipe Line Co.	Natural Gas P/L Co. of America.	10-07-91	C	100,000	N	I	07-27-91	Indef.
ST92-0083	Houston Pipe Line Co.	Humble Gas Transmission Co.	10-07-91	C	10,000	N	I	08-08-91	Indef.
ST92-0084	Houston Pipe Line Co.	Natural Gas P/L Co. of America.	10-07-91	C	100,000	N	I	07-05-91	Indef.
ST92-0085	Houston Pipe Line Co.	Texas Eastern Transmission Corp.	10-07-91	C	100,000	N	I	07-01-91	Indef.
ST92-0086	Houston Pipe Line Co.	Natural Gas P/L Co. of America.	10-07-91	C	100,000	N	I	08-10-91	Indef.
ST92-0087	Houston Pipe Line Co.	El Paso Natural Gas Co.	10-07-91	C	100,000	N	I	07-09-91	Indef.
ST92-0088	Houston Pipe Line Co.	Tennessee Gas Pipeline Co.	10-07-91	C	35,000	N	I	08-07-91	Indef.
ST92-0089	Louisiana Resources Co.	Florida Gas Transmission Co.	10-07-91	C	50,000	N	I	10-01-91	Indef.
ST92-0090	Louisiana Resources Co.	Sea Robin Pipeline Co.	10-07-91	C	20,000	N	I	10-01-91	Indef.
ST92-0091	Transcontinental Gas P/L Corp.	Natural Gas P/L Co. of America.	10-07-91	G	300,000	N	I	09-01-91	Indef.
ST92-0092	Monterey Pipeline Co.	Eastern Gas Pipe Line Co.	10-08-91	C	25,000	N	I	07-01-91	Indef.
ST92-0093	Monterey Pipeline Co.	Tennessee Gas Pipe Line Co.	10-08-91	C	25,000	N	I	07-18-91	Indef.
ST92-0094	Pacific Gas Transmission Co.	Cascade Natural Gas Corp.	10-08-91	B	3,637	N	I	09-13-91	09-01-93.
ST92-0095	Viking Gas Transmission Co.	TXG Gas Marketing Co.	10-08-91	G-S	100,000	N	I	09-02-91	12-31-91.
ST92-0096	Tennessee Gas Pipeline Co.	Credle Gas Pipeline Co.	10-08-91	B	400,000	Y	I	08-02-91	Indef.
ST92-0097	Channel Industries Gas Co.	Natural Gas P/L Co. of America.	10-09-91	C	37,500	N	I	09-26-91	Indef.
ST92-0098	Tennessee Gas Pipeline Co.	Chevron USA Inc.	10-09-91	G-S	50,000	N	I	09-01-91	12-30-91.
ST92-0099	Delhi Gas Pipeline Corp.	Panhandle Eastern Pipeline Co.	10-09-91	C	2,000	N	I	09-26-91	Indef.
ST92-0100	Natural Gas P/L Co. of America.	Columbia Gas Development Corp.	10-09-91	G-S	50,000	N	I	09-12-91	01-10-92.
ST92-0101	Natural Gas P/L Co. of America.	Colorado Interstate Gas Co.	10-09-91	G	100,000	N	I	09-11-91	09-30-92.
ST92-0102	Trunkline Gas Co.	Enron Gas Marketing, Inc.	10-09-91	G-S	100,000	N	I	09-14-91	01-12-92.
ST92-0103	Trunkline Gas Co.	BP Gas, Inc.	10-09-91	G-S	75,000	N	I	09-14-91	01-12-92.
ST92-0104	Trunkline Gas Co.	Bishop Pipeline Corp.	10-09-91	G-S	50,000	N	I	09-14-91	01-12-92.
ST92-0105	Trunkline Gas Co.	Loutex Energy, Inc.	10-09-91	G-S	40,000	N	I	09-14-91	01-12-92.
ST92-0106	Colorado Interstate Gas Co.	Santa Fe Minerals, Inc.	10-09-91	G-S	5,000	N	I	09-08-91	01-06-92.
ST92-0107	Colorado Interstate Gas Co.	Texas Gas Marketing Inc.	10-10-91	G-S	5,000	N	I	09-13-91	01-11-92.
ST92-0108	Colorado Interstate Gas Co.	Western Gas Processors, Ltd.	10-10-91	G-S	50,000	N	I	09-07-91	01-05-92.
ST92-0109	Colorado Interstate Gas Co.	Northern Natural Gas Co.	10-10-91	G-S	50,000	N	I	09-14-91	Indef.
ST92-0110	U-T Offshore System.	Corpus Christi Oil and Gas Co.	10-10-91	K-S	20,000	N	I	09-14-91	01-11-92.
ST92-0111	Transcontinental Gas P/L Corp.	Yuma Gas Corp.	10-10-91	G-S	160,000	N	I	09-11-91	01-08-92.
ST92-0112	Transcontinental Gas P/L Corp.	Ameranda Hess Corp.	10-10-91	G-S	650,000	N	I	09-12-91	01-09-92.
ST92-0113	Superior Offshore Pipeline Co.	Columbia Gas Distribution Co.	10-10-91	B	25,000	N	I	09-01-91	Indef.
ST92-0114	Superior Offshore Pipeline.	Columbia Gas Distribution Co.	10-10-91	B	25,000	N	I	09-01-91	Indef.
ST92-0115	Superior Offshore Pipeline Co.	Columbia Gas Distribution Co.	10-10-91	B	25,000	N	I	09-01-91	Indef.

Docket No. ¹	Transporter/seller	Recipient	Date filed	Part 284 subpart	Est. max. daily quantity ²	Aff. Y/N	Rate schedule	Date commenced	Projected termination date
ST92-0116	Tennessee Gas Pipeline Co.	Kerr McGee Corp.	10-10-91	G-S	1,215,000	N	I	09-12-91	01-10-92
ST92-0117	Valero Transmission, L.P.	Tennessee Gas Pipeline Co.	10-11-91	C	13,000	N	I	10-01-91	Indef.
ST92-0118	Trailblazer Pipeline Co.	Colorado Interstate Gas Co.	10-11-91	G	100,000	N	I	09-11-91	09-30-92
ST92-0119	Natural Gas P/L Co. of America.	Centennial Natural Gas Corp.	10-11-91	G-S	100,000	N	I	09-16-91	01-14-92
ST92-0120	Natural Gas P/L Co. of America.	Equitable Resources Marketing Co.	10-11-91	G-S	50,000	N	I	09-15-91	01-13-92
ST92-0121	Trunkline Gas Co.	Northern Indiana Public Service Co.	10-11-91	G-S	15,000	N	I	09-01-91	12-30-91
ST92-0122	Trunkline Gas Co.	Tejas Hydrocarbons Co.	10-11-91	G-S	100,000	N	I	09-25-91	01-23-92
ST92-0123	Trunkline Gas Co.	Tejas Hydrocarbons Co.	10-11-91	G-S	100,000	N	I	09-30-91	01-28-92
ST92-0124	Trunkline Gas Co.	Howell Gas Management Co.	10-11-91	G-S	50,000	N	I	09-25-91	01-23-92
ST92-0125	Trunkline Gas Co.	Tejas Hydrocarbons Co.	10-11-91	G-S	100,000	N	I	09-30-91	01-28-92
ST92-0126	Texas Eastern Transmission Corp.	CNG Transmission Corp.	10-11-91	G	850,000	N	I	09-10-91	11-01-92
ST92-0127	Texas Eastern Transmission Corp.	Appalachian Gas Sales.	10-11-91	G-S	10,000	N	I	09-07-91	01-05-92
ST92-0128	Texas Eastern Transmission Corp.	Texas Southeastern Gas Corp.	10-11-91	B	20,000	N	I	09-01-91	11-01-92
ST92-0129	Texas Eastern Transmission Corp.	North Jersey Energy Associates.	10-11-91	G-S	75,000	N	I	09-01-91	12-30-91
ST92-0130	Texas Eastern Transmission Corp.	Northeast Energy Associates.	10-11-91	G-S	150,000	N	I	09-10-91	01-08-92
ST92-0131	United Gas Pipe Line Co.	Red River Gas Co.	10-11-91	G-S	1,048	N	I	09-30-91	01-28-92
ST92-0132	United Gas Pipe Line Co.	Enron Gas Marketing, Inc.	10-11-91	G-S	33,500	N	F	10-01-91	01-29-92
ST92-0133	United Gas Pipe Line Co.	Midcon Marketing Corp.	10-11-91	G-S	74,198	N	F	10-01-91	01-29-92
ST92-0134	Columbia Gulf Transmission Co.	Southern Natural Gas Co.	10-11-91	G	53,000	N	F	09-15-91	01-12-92
ST92-0135	Columbia Gulf Transmission Co.	Energy Marketing Exchange, Inc.	10-11-91	G-S	60,000	N	I	09-24-91	01-21-92
ST92-0136	Columbia Gulf Transmission Co.	Southern Natural Gas Co.	10-11-91	G	40,000	N	I	09-22-91	01-19-92
ST92-0137	Western Gas Supply Co.	Trailblazer Gas Co.	10-11-91	C	30,000	N	I	03-01-91	Indef.
ST92-0138	Western Gas Supply Co.	Trailblazer Gas Co.	10-11-91	C	5,000	N	I	06-01-91	Indef.
ST92-0139	Western Gas Supply Co.	Trailblazer Gas Co.	10-11-91	C	3,000	N	I	04-01-91	Indef.
ST92-0140	Williston Basin Inter. P/L Co.	Western Gas Resources, Inc.	10-11-91	G-S	142,800	N	I	09-12-91	05-23-93
ST92-0141	Williston Basin Inter. P/L Co.	Amerasia Hess Corp.	10-11-91	G-S	63,000	N	I	09-14-91	09-05-93
ST92-0142	Williston Basin Inter. P/L Co.	Rainbow Gas Co.	10-11-91	G-S	318,863	N	I	10-01-91	07-31-92
ST92-0143	ANR Pipeline Co.	Consolidated Edison Co. of NY, Inc.	10-11-91	B	600,000	Y	I	09-11-91	Indef.
ST92-0144	Montana Power Co.	Montana-Dakota Utilities Co.	10-15-91	C	20,000	N	I	09-13-91	10-31-92
ST92-0145	Acadian Gas Pipeline System.	Transcontinental Gas P/L Corp.	10-15-91	C	10,000	N	F	10-01-91	Indef.
ST92-0146	Lone Star Gas Co.	El Paso Natural Gas Co.	10-15-91	C	100,000	N	I	09-17-91	Indef.
ST92-0147	ONG Transmission Co.	Natural Gas P/L Co. of America.	10-15-91	C	100,000	N	I	09-15-91	Indef.
ST92-0148	Enogex Inc.	Williams Natural Gas Co.	10-15-91	C	30,000	N	I	09-20-91	Indef.
ST92-0149	Enogex Inc.	Natural Gas P/L Co. of America.	10-15-91	C	30,000	N	I	09-26-91	Indef.
ST92-0150	Enogex Inc.	Northern Natural Gas Co.	10-15-91	C	15,000	N	I	09-20-91	Indef.
ST92-0151	Enogex Inc.	ANR Pipeline Co.	10-15-91	C	10,000	N	I	09-21-91	Indef.
ST92-0152	Enogex Inc.	Northern Natural Gas Co.	10-15-91	C	15,000	N	I	09-23-91	Indef.
ST92-0153	Delhi Gas Pipeline Corp.	Natural Gas P/L Co. of America.	10-15-91	C	15,000	N	I	10-01-91	Indef.
ST92-0154	Delhi Gas Pipeline Corp.	Natural Gas P/L Co. of America.	10-15-91	C	15,000	N	I	10-01-91	Indef.
ST92-0155	Transok, Inc.	Natural Gas P/L Co. of America.	10-15-91	C	15,000	N	I	10-01-91	Indef.
ST92-0155	Transok, Inc.	Natural Gas P/L Co. of America.	10-15-91	C	15,000	N	I	10-01-91	Indef.
ST92-0156	Southern Natural Gas Co.	South Carolina Pipeline Corp.	10-15-91	G-S	50,000	N	F	10-01-91	01-29-92
ST92-0157	Southern Natural Gas Co.	City of Jasper	10-15-91	G-S	266	N	F	10-01-91	01-29-92
ST92-0158	Southern Natural Gas Co.	City of Havana	10-15-91	G-S	201	N	F	10-01-91	01-29-92
ST92-0159	Southern Natural Gas Co.	City of Adairsville	10-15-91	G-S	170	N	F	10-01-91	01-29-92
ST92-0160	Tennessee Gas Pipeline Co.	Enmark Gas Corp.	10-15-91	G-S	47,250	N	I	10-10-91	02-07-92

Docket No. ¹	Transporter/seller	Recipient	Date filed	Part 284 subpart	Est. max. daily quantity ²	Aff. Y/N	Rate schedule	Date commenced	Projected termination date
ST92-0161	Tennessee Gas Pipeline Co.	Stand Energy Corp.	10-15-91	G-S	10,000	N	I	09-12-91	01-10-92.
ST92-0162	Tennessee Gas Pipeline Co.	Southern Gas Co., Inc.	10-15-91	G-S	32,000	N	I	09-12-91	01-10-92.
ST92-0163	Tennessee Gas Pipeline Co.	Tejas Hydrocarbons Co.	10-15-91	G-S	15,000	N	L	09-19-91	01-17-92.
ST92-0164	Tennessee Gas Pipeline Co.	Shell Gas Trading Co.	10-15-91	G-S	500,000	N	I	09-01-91	12-30-91.
ST92-0166	South Georgia Natural Gas Co.	City of Jasper	10-15-91	G-S	265	N	F	10-01-91	01-29-92.
ST92-0167	South Georgia Natural Gas Co.	City of Havana	10-15-91	G-S	200	N	F	10-01-91	01-29-92.
ST92-0168	Sea Robin Pipeline Co.	CNG Producing Co.	10-15-91	G-S	60,000	N	I	10-02-91	01-30-92.
ST92-0169	Columbia Gas Transmission Corp.	Tivis Newsom	10-15-91	G-S	1,820	N	F/I	10-10-91	02-07-92.
ST92-0170	Panhandle Eastern Pipe Line Co.	Teepak, Inc.	10-15-91	G-S	500	N	F	09-01-91	12-30-91.
ST92-0171	Panhandle Eastern Pipe Line Co.	Maco Corp.	10-15-91	G-S	1,900	N	F	09-01-91	12-30-91.
ST92-0172	Gas Company of New Mexico.	El Paso Natural Gas Co.	10-15-91	G-HT	3,500	N	F	03-01-91	02-29-92.
ST92-0173	Florida Gas Transmission Co.	St. Joe Natural Gas Co.	10-15-91	G-S	1,140	N	I	10-01-91	Indef.
ST92-0174	Florida Gas Transmission Co.	Procter & Gamble Cellulose Co.	10-15-91	G-S	4,393	N	I	09-24-91	Indef.
ST92-0175	ONG Transmission Co.	Northern Natural Gas Co.	10-16-91	C	30,000	N	I	09-18-91	Indef.
ST92-0176	Northern Natural Gas Co.	Northwestern Public Service Co.	10-15-91	B	1,860	N	F	10-01-91	Indef.
ST92-0177	Northern Natural Gas Co.	Northwestern Public Service Co.	10-15-91	B	3,605	N	F	09-01-91	Indef.
ST92-0178	Northern Natural Gas Co.	Cibola Corp.	10-15-91	G-S	75,000	N	I	09-01-91	Indef.
ST92-0179	Northern Natural Gas Co.	Panda Resources, Inc.	10-15-91	G-S	500,000	N	F/I	09-26-91	01-24-92.
ST92-0180	Sabine Pipe Line Co.	Houston Pipe Line Co.	10-15-91	B	180,000	N	I	08-09-90	Indef.
ST92-0181	United Gas Pipe Line Co.	Oryx Gas Marketing Ltd Partnership.	10-16-91	G-S	62,880	N	I	10-08-91	02-05-92.
ST92-0182	United Gas Pipe Line Co.	Desoto Pipeline Co., Inc.	10-16-91	G-S	5,240	N	I	10-07-91	02-04-92.
ST92-0183	United Gas Pipe Line Co.	Endevco Oil & Gas Co.	10-16-91	G-S	26,200	N	I	10-08-91	02-05-92.
ST92-0184	United Gas Pipe Line Co.	Exxon Corp.	10-16-91	G-S	104,800	N	I	10-04-91	02-01-92.
ST92-0185	United Gas Pipe Line Co.	Arkla Energy Marketing Co.	10-16-91	G-S	209,600	N	I	10-08-91	02-05-92.
ST92-0186	United Gas Pipe Line Co.	Ames Financial, Inc.	10-16-91	G-S	15,720	N	I	10-08-91	02-05-92.
ST92-0187	United Gas Pipe Line Co.	Enemark Gas Gathering Corp.	10-16-91	G-S	104,800	N	I	10-10-91	02-07-92.
ST92-0188	Tennessee Gas Pipeline Co.	Catamount Natural Gas, Inc.	10-17-91	G-S	102,600	N	I	09-02-91	12-30-91.
ST92-0189	ANR Pipeline Co.	Southeastern Michigan Gas Co.	10-17-91	B	100,000	N	I	09-20-91	Indef.
ST92-0190	ANR Pipeline Co.	Access Energy Corp.	10-17-91	G-S	67,884	N	I	09-26-91	01-23-92.
ST92-0191	ANR Pipeline Co.	Sonat Marketing Co.	10-17-91	G-S	10,000	N	I	09-27-91	Indef.
ST92-0192	ANR Pipeline Co.	Michigan Gas Utilities Co.	10-17-91	B	33,942	N	I	09-21-91	Indef.
ST92-0193	Arkla Energy Resources	Northern Indiana Public Service Co.	10-17-91	B	60,000	N	I	10-01-91	Indef.
ST92-0195	Arkla Energy Resources	Oryx Gas Marketing L.P.	10-17-91	G-S	60,000	N	I	10-01-91	Indef.
ST92-0196	Arkla Energy Resources	Nitrogen Products Inc.	10-17-91	G-S	2,000	N	I	10-01-91	Indef.
ST92-0197	Arkla Energy Resources	Aquila Energy Marketing Corp.	10-17-91	G-S	10,000	N	I	10-01-91	Indef.
ST92-0198	Arkla Energy Resources	Coastal Gas Marketing Co.	10-17-91	G-S	100,000	N	I	10-10-91	Indef.
ST92-0199	Arkla Energy Resources	Equitable Resources Marketing Co.	10-17-91	G-S	100,000	N	I	10-01-91	Indef.
ST92-0200	Delhi Gas Pipeline Corp.	Panhandle Eastern Pipeline Co.	10-18-91	C	20,000	N	I	10-04-91	Indef.
ST92-0201	Northern Natural Gas Co.	Bridgegas U.S.A. Inc.	10-18-91	G-S	100,000	N	I	10-01-91	01-29-92.
ST92-0202	Northern Natural Gas Co.	Enron Industrial Natural Gas Co.	10-18-91	B	100,000	Y	F/I	10-01-91	Indef.
ST92-0203	Northern Natural Gas Co.	Coastal Gas Marketing Co.	10-18-91	G-S	88,457	N	F/I	09-30-91	01-28-92.
ST92-0204	Northern Natural Gas Co.	Mobil Natural Gas, Inc.	10-18-91	G-S	121,000	N	F	10-01-91	01-29-92.
ST92-0205	Northern Natural Gas Co.	Landmark Gas Corp.	10-18-91	G-S	2,500	N	F/I	10-01-91	01-29-92.
ST92-0206	Northern Natural Gas Co.	Texaco Gas Marketing Inc.	10-18-91	G-S	21,560	N	F	10-01-91	01-29-92.
ST92-0207	Northern Natural Gas Co.	Polaris Pipeline Corp.	10-18-91	G-S	75,000	N	F	09-22-91	01-20-92.
ST92-0208	Transwestern Pipeline Co.	Panda Resources, Inc.	10-18-91	G-S	5,000	N	I	10-04-91	02-01-92.
ST92-0209	Transwestern Pipeline Co.	West Texas Gas, Inc.	10-18-91	G-S	5,000	N	I	10-01-91	01-29-92.
ST92-0210	Texas Gas Transmission Corp.	Transco Energy Marketing Co.	10-18-91	G-S	50,000	N	I	10-02-91	01-29-92.
ST92-0211	Natural Gas P/L Co. of America.	Tennessee Gas Pipeline Co.	10-18-91	G	48,000	N	F	05-16-91	06-29-92.

Docket No. 1	Transporter/seller	Recipient	Date filed	Part 284 subpart	Est. max. daily quantity 2	Aff. Y/N	Rate schedule	Date commenced	Projected termination date
ST92-0212	Natural Gas P/L Co. of America.	Tennessee Gas Pipeline Co.	10-18-91	G	48,000	N	F	05-16-91	06-29-01.
ST92-0213	Natural Gas P/L Co. of America.	Texaco Gas Marketing, Inc.	10-18-91	G-S	200,000	N	I	08-28-91	12-26-91.
ST92-0214	Trailblazer Pipeline Co.	Rangeline Corp.	10-18-91	G-S	353,000	N	I	09-18-91	01-16-92.
ST92-0215	Northwest Pipeline Corp.	Fina Oil & Chemical Co.	10-18-91	G-S	4,000	N	I	09-03-91	Indef.
ST92-0216	Texas Gas Transmission Corp.	CNG Producing Co.	10-18-91	G-S	20,000	N	I	10-02-91	01-29-92.
ST92-0217	Texas Gas Transmission Corp.	Mobil Natural Gas Inc.	10-18-91	G-S	12,120	N	I	10-01-91	01-28-92.
ST92-0218	Texas Gas Transmission Corp.	Equitable Resources Marketing Co.	10-18-91	G-S	56,000	N	I	10-01-91	01-28-92.
ST92-0219	Texas Gas Transmission Corp.	New York Electric & Gas Corp.	10-18-91	G-S	8,230	N	F	10-03-91	01-30-92.
ST92-0220	Texas Gas Transmission Corp.	Hope Gas, Inc.	10-18-91	G-S	5,121	N	F	10-01-91	01-28-92.
ST92-0221	Texas Gas Transmission Corp.	Union Light, Heat and Power Co.	10-18-91	B	9,000	N	F	09-18-91	Indef.
ST92-0222	Texas Gas Transmission Corp.	Cincinnati Gas and Electric Co.	10-18-91	B	5,121	N	F	09-18-91	Indef.
ST92-0223	Tennessee Gas Pipeline Co.	Reliance Gas Marketing Co.	10-21-91	G-S	50,000	N	I	09-19-91	01-17-92.
ST92-0224	Florida Gas Transmission Co.	St. Joe Natural Gas Co.	10-21-91	G-S	3,723	N	F	10-01-91	07-31-93.
ST92-0225	Tennessee Gas Pipeline Co.	O & R Energy Development, Inc.	10-21-91	G-S	300,000	N	I	09-21-91	01-19-92.
ST92-0226	Equitrans, Inc.	Eastern American Energy Corp.	10-21-91	G-S	1,316	N	I	09-01-91	12-29-91.
ST92-0227	Gas Company of New Mexico.	El Paso Natural Gas Co.	10-21-91	G-HT	5,000	N	I	10-01-91	12-30-92.
ST92-0228	Louisiana Intrastate Gas Corp.	Columbia Gas Transmission Corp.	10-21-91	C	25,000	N	I	09-01-91	Indef.
ST92-0229	Great Lakes Gas Trans. L.P.	Ford Motor Co.	10-21-91	G-S	110,00	N	I	09-20-91	01-17-92.
ST92-0230	Transcontinental Gas P/L Corp.	Polaris Pipeline Corp.	10-21-91	G-S	100,00	N	I	09-18-91	07-31-93.
ST92-0231	CNG Transmission Corp.	Polaris Pipeline Corp.	10-21-91	G-S	25,000	N	I	10-01-91	02-14-92.
ST92-0232	CNG Transmission Corp.	Entrade Corp.	10-21-91	G-S	50,000	N	I	10-10-91	02-07-92.
ST92-0233	CNG Transmission Corp.	Appalachian Gas Sales Co.	10-21-91	G-S	5,000	N	I	09-20-91	01-18-92.
ST92-0234	CNG Transmission Corp.	O & R Energy, Inc.	10-21-91	G-S	50,000	N	I	09-08-91	01-30-92.
ST92-0235	CNG Transmission Corp.	Phoenix Diversified Ventures.	10-21-91	G-S	5,000	N	I	09-26-91	01-24-92.
ST92-0236	CNG Transmission Corp.	Steuben Gas Storage Co.	10-21-91	G-S	70,000	N	I	10-03-91	01-31-92.
ST92-0237	Valero Transmission, L.P.	Trunkline Gas Co.	10-21-91	C	20,000	N	I	10-01-91	Indef.
ST92-0238	Valero Transmission, L.P.	Trunkline Gas Co.	10-21-91	C	6,374	Y	I	10-05-91	Indef.
ST92-0239	Tennessee Gas Pipeline Co.	Columbia Gas Transmission Corp.	10-22-91	G	5,000	N	I	10-01-91	Indef.
ST92-0240	Texas Gas Transmission Corp.	Stellar Gas Co.	10-22-91	G-S	40,000	N	I	10-01-91	01-28-92.
ST92-0241	Texas Gas Transmission Corp.	NGC Transportation, Inc.	10-22-91	G-S	100,000	N	I	10-01-91	01-28-92.
ST92-0242	Texas Gas Transmission Corp.	Tejas Power Corp.	10-22-91	G-S	100,000	N	I	10-08-91	02-04-92.
ST92-0243	Natural Gas P/L Co. of America.	Grain Processing Corp.	10-22-91	G-S	4,000	N	F	10-01-91	01-29-92.
ST92-0244	Natural Gas P/L Co. of America.	Archer-Daniels-Midland Co.	10-22-91	G-S	10,000	N	F	10-01-91	01-29-92.
ST92-0245	Natural Gas P/L Co. of America.	Archer-Daniels-Midland Co.	10-22-91	G-S	10,000	N	F	10-01-91	01-29-92.
ST92-0246	Natural Gas P/L Co. of America.	Quantum Chemical Corp.	10-22-91	G-S	15,076	N	F	09-01-91	12-30-91.
ST92-0247	Trunkline Gas Co.	Arkla Louisiana Gas Co.	10-22-91	B	50,000	N	I	10-08-91	11-07-91.
ST92-0248	Panhandle Eastern Pipe Line Co.	O & R Energy, Inc.	10-22-91	G-S	50,000	N	I	10-01-91	01-29-92.
ST92-0249	Panhandle Eastern Pipe Line Co.	Howell Gas Management Co.	10-22-91	G-S	50,000	N	I	09-25-91	01-23-92.
ST92-0250	Panhandle Eastern Pipe Line Co.	Midland Cogeneration Venture, L.P.	10-22-91	G-S	15,000	N	I	10-01-91	01-29-92.
ST92-0251	Panhandle Eastern Pipe Line Co.	Northern Indiana Public Service Co.	10-22-91	G-S	12,000	N	I	10-01-91	01-29-92.
ST92-0252	Panhandle Eastern Pipe Line Co.	Holiday Inn East.	10-22-91	G-S	12,960	N	F	10-01-91	01-29-92.
ST92-0253	Panhandle Eastern Pipe Line Co.	Amgas, Inc.	10-22-91	G-S	60	N	I	10-01-91	01-29-92.
ST92-0254	Panhandle Eastern Pipe Line Co.	State of Michigan.	10-22-91	G-S	1,500	N	I	10-01-91	01-29-92.
ST92-0255	Panhandle Eastern Pipe Line Co.	North American Resources Co.	10-22-91	G-S	20,000	N	I	10-01-91	01-29-92.

Docket No. ¹	Transporter/seller	Recipient	Date filed	Part 284 subpart	Est. max. daily quantity ²	Aff. Y/N	Rate schedule	Date commenced	Projected termination date
ST92-0256	El Paso Natural Gas Co....	Texaco Gas Marketing Inc.	10-22-91	G-S	5,150	Y	I	10-01-91	09-20-92.
ST92-0257	Transcontinental Gas P/L Corp.	Mid Louisiana Gas Co.....	10-22-91	G	277,000	N	I	10-01-91	Indef.
ST92-0258	Questar Pipeline Co.....	Celsius Energy Co.....	10-23-91	G-S	90,000	N	I	10-11-91	02-07-92.
ST92-0259	Tennessee Gas Pipeline Co.	Boston Gas Co.....	10-23-91	B	395,010	N	I	07-03-91	Indef.
ST92-0260	Columbia Gas Transmission Corp.	Columbia Gas of Ohio, Inc.	10-23-91	B	30	Y	I	10-01-91	Indef.
ST92-0261	Columbia Gas Transmission Corp.	Kalida Natural Gas Co., Inc.	10-23-91	B	1,500	N	I	10-02-91	Indef.
ST92-0262	Columbia Gas Transmission Corp.	J.W. Kinzer.....	10-23-91	G-S	6,325	N	I	10-10-91	Indef.
ST92-0263	Natural Gas P/L Co. of America.	Midcon Marketing Corp.....	10-23-91	G-S	20,000	Y	I	09-21-91	01-19-92.
ST92-0264	Natural Gas P/L Co. of America.	Bridgegas U.S.A. Inc.....	10-23-91	G-S	100,000	N	I	10-01-91	01-29-92.
ST92-0265	Natural Gas P/L Co. of America.	Access Energy Corp.....	10-23-91	G-S	1,100	N	F	10-01-91	01-29-92.
ST92-0266	Natural Gas P/L Co. of America.	Bishop Pipeline Corp.....	10-23-91	G-S	50,000	N	I	10-01-91	01-29-92.
ST92-0267	Natural Gas P/L Co. of America.	Highland Energy Co.....	10-23-91	G-S	5,000	N	I	10-01-91	01-29-92.
ST92-0268	Florida Gas Transmission Co.	Houston Pipe Line Co.....	10-23-91	B	50,000	N	I	04-17-91	Indef.
ST92-0269	Colorado Interstate Gas Co.	Kimball Energy Corp.....	10-23-91	G-S	10,000	N	I	10-01-91	01-29-92.
ST92-0270	Colorado Interstate Gas Co.	Ideal Cement Div., Holnam, Inc.	10-23-91	G-S	125	N	F	09-27-91	01-25-92.
ST92-0271	Colorado Interstate Gas Co.	Texaco Gas Marketing Inc.	10-23-91	G-S	8,000	N	F	11-01-91	02-29-92.
ST92-0272	Colorado Interstate Gas Co.	Western Natural Gas & Trans. Corp.	10-23-91	G-S	10,000	N	I	10-05-91	02-03-92.
ST92-0273	Colorado Interstate Gas Co.	Grand Valley Gas Co.....	10-23-91	G-S	50,000	N	I	10-01-91	02-29-92.
ST92-0274	Questar Pipeline Co.....	Williams Gas Marketing Co.	10-24-91	G-S	54,000	N	I	09-24-91	01-21-92.
ST92-0275	Traillblazer Pipeline Co.....	KN Energy, Inc.....	10-24-91	G	42,500	N	F	10-01-91	08-31-95.
ST92-0276	Natural Gas P/L Co. of America.	Boyd Rosene and Assoc., Inc.	10-24-91	G	25,000	N	I	10-01-91	Indef.
ST92-0277	Texas Gas Transmission Corp.	Consolidated Edison Co. of NY, Inc.	10-24-91	B	260,000	Y	I	10-07-91	Indef.
ST92-0278	Texas Gas Transmission Corp.	Bridgeline Gas Distribution Co.	10-24-91	B	50,000	N	I	10-16-91	Indef.
ST92-0279	Texas Gas Transmission Corp.	Western Kentucky Gas Co.	10-24-91	B	22,750	N	F	10-01-91	Indef.
ST92-0280	Texas Gas Transmission Corp.	Consolidated Edison Co. of NY, Inc.	10-24-91	B	260,000	N	I	10-07-91	Indef.
ST92-0281	Texas Gas Transmission Corp.	Bridgeline Gas Distribution Co.	10-24-91	B	50,000	N	I	10-01-91	Indef.
ST92-0282	Texas Gas Transmission Corp.	Consolidated Edison Co. of NY, Inc.	10-24-91	B	260,000	N	I	10-07-91	Indef.
ST92-0283	Williston Basin Inter. P/L Co.	Rainbow Gas Co.....	10-24-91	G-S	91,890	Y	I	10-17-91	08-31-92.
ST92-0284	Panhandle Eastern Pipe Line Co.	Bishop Pipeline Corp.....	10-24-91	G-S	5,000	N	F	10-01-91	01-29-92.
ST92-0285	Panhandle Eastern Pipe Line Co.	Central Illinois Public Service Co.	10-24-91	G-S	8,775	N	F	10-01-91	01-29-92.
ST92-0286	Panhandle Eastern Pipe Line Co.	Ramada Renaissance Hotel.	10-24-91	G-S	100	N	F	10-01-91	01-29-92.
ST92-0287	Panhandle Eastern Pipe Line Co.	Springfield Hilton.....	10-24-91	G-S	114	N	F	10-01-91	01-29-92.
ST92-0288	Panhandle Eastern Pipe Line Co.	Taurus Energy Corp.....	10-24-91	G-S	5,000	N	I	10-01-91	01-29-92.
ST92-0289	Panhandle Eastern Pipe Line Co.	Amerada Hess Corp.....	10-24-91	G-S	100,000	N	I	10-01-91	01-29-92.
ST92-0290	Panhandle Eastern Pipe Line Co.	Amgas, Inc.....	10-24-91	G-S	200	N	I	10-01-91	01-29-92.
ST92-0291	Panhandle Eastern Pipe Line Co.	Continental Natural Gas, Inc.	10-24-91	G-S	10,000	N	I	10-01-91	01-29-92.
ST92-0292	Arkla Energy Resources...	Memphis Light, Gas & Water.	10-24-91	B	11,000	N	F	10-01-91	Indef.
ST92-0293	Florida Gas Transmission Co.	Seminole Fertilizer Corp....	10-24-91	G-S	1,233	N	I	10-01-91	07-16-93.
ST92-0294	Florida Gas Transmission Co.	Fl. Pierce Utilities Authority.	10-24-91	G-S	1,650	N	F	10-01-91	Indef.
ST92-0295	Florida Gas Transmission Co.	City of Clearwater.....	10-24-91	G-S	3,066	N	F	10-01-91	Indef.
ST92-0296	Transcontinental Gas P/L Corp.	Channel Indust. Gas Co., et al.	10-24-91	B	1,350,000	N	I	09-01-91	Indef.

Docket No. ¹	Transporter/seller	Recipient	Date filed	Part 284 subpart	Est. max. daily quantity ²	Aff. Y/N	Rate schedule	Date commenced	Projected termination date
ST92-0297	ANR Pipeline Co.....	Atlantic Gas Light Co.....	10-24-91	B	100,000	Y	I	09-18-91	Indef.
ST92-0298	Valero Transmission, L.P..	United Gas Pipeline Co.....	10-25-91	C	2,800	N	I	10-18-91	Indef.
ST92-0299	Valero Transmission, L.P..	Natural Gas P/L Co. of America.	10-25-91	C	10,000	N	I	10-01-91	Indef.
ST92-0300	Valero Transmission, L.P..	El Paso Natural Gas Co....	10-25-91	C	10,000	N	I	10-08-91	Indef.
ST92-0301	Transok, Inc.....	Intersearch Gas Corp.....	10-25-91	C	200	N	I	09-01-91	Indef.
ST92-0302	Transcontinental Gas P/L Corp.	Florida Gas Transmission Co.	10-25-91	G	30,000	N	I	12-12-88	Indef.
ST92-0303	Transcontinental Gas P/L Corp.	Hadson Gas Systems.....	10-25-91	G-S	500,000	N	I	10-01-91	Indef.
ST92-0304	Transcontinental Gas P/L Corp.	Energy Marketing Exchange, Inc.	10-25-91	G-S	40,000	N	I	10-02-91	Indef.
ST92-0305	Transcontinental Gas P/L Corp.	Trinity Pipeline, Inc.....	10-25-91	G-S	500,000	N	I	10-01-91	Indef.
ST92-0306	Columbia Gulf Transmission Co.	Gasmark, Inc.....	10-25-91	G-S	100,000	N	I	10-01-91	01-28-92.
ST92-0307	Columbia Gulf Transmission Co.	Union Pacific Fuels, Inc....	10-25-91	G-S	25,000	N	I	10-01-91	01-28-92.
ST92-0308	Columbia Gulf Transmission Co.	United Cities Gas Co.....	10-25-91	B	30,000	N	I	10-01-91	01-28-92.
ST92-0309	Columbia Gulf Transmission Co.	Catex Energy, Inc.....	10-25-91	G-S	100,000	N	I	10-01-91	01-28-92.
ST92-0310	Columbia Gulf Transmission Co.	Koch Hydrocarbon Co.....	10-25-91	G-S	100,000	N	I	10-01-91	01-28-92.
ST92-0311	Columbia Gulf Transmission Co.	Tejas Power Corp.....	10-25-91	G-S	150,000	N	I	10-02-91	01-29-92.
ST92-0312	Columbia Gulf Transmission Co.	Energy Development Corp.	10-25-91	G-S	14,074	N	F	10-01-91	01-28-92.
ST92-0313	Columbia Gulf Transmission Co.	Chevron U.S.A., Inc.....	10-25-91	G-S	8,000	N	F	10-01-91	01-28-92.
ST92-0314	Columbia Gulf Transmission Co.	Diamond Shamrock Off. Part. L.P.	10-25-91	G-S	100,000	N	I	10-01-91	01-28-92.
ST92-0315	Ong Transmission Co.....	Panhandle Eastern Pipe Line Co.	10-28-91	C	30,000	N	I	09-28-91	Indef.
ST92-0316	Ong Transmission Co.....	Anr Pipeline Co.....	10-28-91	C	50,000	N	I	09-30-91	Indef.
ST92-0317	Ong Transmission Co.....	Ozark Pipeline Co.....	10-28-91	C	10,000	N	I	10-01-91	Indef.
ST92-0318	Ozark Gas Transmission System.	Northern Illinois Gas Co....	10-28-91	B	10,000	N	I	10-10-91	Indef.
ST92-0319	Ozark Gas Transmission System.	Polaris Pipeline Corp.....	10-28-91	G-S	65,000	N	I	10-01-91	Indef.
ST92-0320	Ozark Gas Transmission System.	Tennessee Gas Pipeline Co.	10-28-91	G	60,000	Y	I	10-12-91	Indef.
ST92-0321	Ozark Gas Transmission System.	Reliance Pipeline Co.....	10-28-91	B	50,000	N	I	10-01-91	Indef.
ST92-0322	Ozark Gas Transmission System.	Fina Natural Gas Co.....	10-28-91	G-S	7,500	N	I	10-01-91	09-30-92.
ST92-0323	Ozark Gas Transmission System.	Arco Natural Gas Marketing, Inc.	10-28-91	G-S	100,000	N	I	10-01-91	09-30-92.
ST92-0324	Ozark Gas Transmission System.	Santa Fe Minerals, Inc.....	10-28-91	G-S	50,000	N	I	10-01-91	09-30-92.
ST92-0325	Ozark Gas Transmission System.	Texaco Gas Marketing, Inc.	10-28-91	G-S	50,000	N	I	10-01-91	09-30-92.
ST92-0326	Gas Co. of New Mexico....	El Paso Natural Gas Co....	10-28-91	G-HT	5,000	N	I	09-25-91	09-25-91.
ST92-0327	Tennessee Gas Pipeline Co.	Quivira Gas Co.....	10-28-91	G-S	204,000	N	I	09-28-91	01-26-92.
ST92-0328	Arkla Energy Resources...	Cincinnati Gas & Electric, et al.	10-28-91	B	45,000	N	F	10-23-91	Indef.
ST92-0329	Transcontinental Gas P/L Corp.	National Fuel Gas Supply.	10-29-91	G	25,000	N	I	10-18-91	Indef.
ST92-0330	Transcontinental Gas P/L Corp.	York Research Corp.....	10-29-91	G-S	40,000	N	I	10-18-91	Indef.
ST92-0331	East Tennessee Natural Gas Co.	Channel Industrial Gas Co.	10-29-91	G-S	40,000	N	I	10-18-91	Indef.
ST92-0332	East Tennessee Natural Gas Co.	Chattanooga Gas Co.....	10-29-91	B	500,000	N	I	10-18-91	Indef.
ST92-0333	East Tennessee Natural Gas Co.	Houston Pipeline Co.....	10-29-91	B	7,650	N	I	10-11-91	Indef.
ST92-0334	East Tennessee Natural Gas Co.	Houston Pipeline Co.....	10-29-91	B	500,000	N	I	10-02-91	Indef.
ST92-0335	East Tennessee Natural Gas Co.	Bridgeline Gas Distribution Co.	10-29-91	B	200,000	N	I	10-02-91	Indef.
ST92-0336	Ozark Gas Transmission System.	Boyd Rosene and Assoc., Inc.	10-29-91	G-S	30,000	N	I	10-01-91	09-30-92.
ST92-0337	Ozark Gas Transmission System.	Bishop Pipeline Corp.....	10-29-91	G-S	40,000	N	I	10-01-91	09-30-92.
ST92-0338	Ozark Gas Transmission System.	Production Gathering Co..	10-29-91	G-S	10,000	N	I	10-01-91	09-30-92.
ST92-0339	Ozark Gas Transmission System.	Industrial Energy Applications, Inc.	10-29-91	G-S	40,000	N	I	10-01-91	09-30-92.

Docket No.	Transporter/seller	Recipient	Date filed	Part 284 subpart	Est. max. daily quantity	Aff. Y/N	Rate schedule	Date commenced	Projected termination date
ST92-0340	Ozark Gas Transmission System.	Highland Energy Co.....	10-29-91	G-S	5,500	N	I	10-01-91	09-30-92.
ST92-0341	Ozark Gas Transmission System.	International Paper Co.....	10-29-91	G-S	100,000	N	I	10-01-91	09-30-92.
ST92-0342	Ozark Gas Transmission System.	Premier Gas Co.....	10-29-91	G-S	5,000	N	I	10-01-91	09-30-92.
ST92-0343	Ozark Gas Transmission System.	American Central Gas Cos., Inc.	10-29-91	G-S	50,000	N	I	10-01-91	09-30-92.
ST92-0344	Ozark Gas Transmission System.	Sonat Exploration Co.....	10-29-91	G-S	100,000	N	I	10-01-91	09-30-92.
ST92-0345	Ozark Gas Transmission System.	Servco Gas Marketing, Inc.	10-29-91	G-S	10,000	N	I	10-01-91	09-30-92.
ST92-0346	Ozark Gas Transmission System.	NGC Transportation Inc....	10-29-91	G-S	100,000	N	I	10-01-91	09-30-92.
ST92-0347	Ozark Gas Transmission System.	Nicor Gas Marketing Co....	10-29-91	G-S	50,000	N	I	10-01-91	09-30-92.
ST92-0348	Red River Pipeline.....	KN Energy, Inc.....	10-29-91	C	250,000	N	I	10-02-91	Indef.
ST92-0349	Tennessee Gas Pipeline Co.	North Atlantic Utilities, Inc.	10-29-91	G-S	10,000	N	I	10-02-91	01-30-92.
ST92-0350	Transcontinental Gas P/L Corp.	Brooklyn Union Gas Co....	10-29-91	B	70,725	N	F	10-18-91	03-31-05.
ST92-0351	Transcontinental Gas P/L Corp.	Consolidated Edison Co....	10-29-91	B	7,580,000	N	I	04-29-91	Indef.
ST92-0381	Trailblazer Pipeline Co.....	Chevron U.S.A. Inc.....	10-30-91	G-S	353,000	N	I	10-01-91	01-29-92.
ST92-0382	Moraine Pipeline Co.....	Wisconsin Natural Gas Co.	10-30-91	B	10,000	Y	F	10-01-91	09-30-01.
ST92-0383	Natural Gas P/L Co. of America.	Northern Illinois Gas Co....	10-30-91	B	75,000	N	F	10-01-91	11-30-95.
ST92-0384	Natural Gas P/L Co. of America.	Wisconsin Natural Gas Co.	10-30-91	B	10,000	N	F	10-01-91	09-30-00.
ST92-0385	Natural Gas P/L Co. of America.	Vesta Energy Co.....	10-30-91	G-S	50,000	N	I	10-04-91	02-01-92.
ST92-0386	Natural Gas P/L Co. of America.	Shell Gas Trading Co.....	10-30-91	G-S	300,000	N	I	10-03-91	01-31-92.
ST92-0388	Mid Louisiana Gas Co.....	LA Mun. Nat. Gas Purch. & Dis. Au.	10-30-91	G-S	4,735	N	F	10-01-91	01-28-92.
ST92-0389	Lone Star Gas Co.....	Natural Gas P/L Co. of America.	10-30-91	C	50,000	N	I	10-01-91	Indef.
ST92-0390	Williston Basin Inter. P/L Co.	PrairieLand Energy Marketing Inc.	10-30-91	G-S	37,000	Y	I	10-22-91	10-14-92.
ST92-0391	Williston Basin Inter. P/L Co.	Hiland Partners.....	10-30-91	G-S	69,800	Y	I	10-08-91	05-31-93.
ST92-0392	Williston Basin Inter. P/L Co.	Texaco Gas Marketing, Inc.	10-30-91	G-S	37,100	N	I	09-30-91	09-30-92.
ST92-0393	Mississippi River Trans. Corp.	ARKLA Energy Marketing Co.	10-30-91	G-S	8,000	Y	F	10-01-91	01-29-92.
ST92-0394	United Gas Pipe Line Co.	Bishop Pipeline Corp.....	10-30-91	G-S	41,920	N	I	10-16-91	02-13-92.
ST92-0395	ANR Pipeline Co.....	Southeastern Michigan Gas Co.	10-30-91	B	100,000	N	I	10-04-91	Indef.
ST92-0396	ANR Pipeline Co.....	Aquila Energy Marketing Corp.	10-30-91	G-S	5,000	N	F	07-17-91	10-01-91.
ST92-0397	ANR Pipeline Co.....	City of Jasper.....	10-30-91	B	3,000	N	F	10-01-91	12-31-05.
ST92-0398	ANR Pipeline Co.....	Headington Penn Corp.....	10-30-91	G-S	50	N	I	10-07-91	Indef.
ST92-0399	ANR Pipeline Co.....	Gas Energy Development Co.	10-30-91	G-S	30,000	N	I	10-01-91	Indef.
ST92-0400	ANR Pipeline Co.....	Kaztex Energy Management, Inc.	10-30-91	G-S	75,000	N	I	10-02-91	Indef.
ST92-0401	ANR Pipeline Co.....	Interstate Gas Marketing, Inc.	10-30-91	G-S	3,300	N	F	10-05-91	09-30-92.
ST92-0402	ANR Pipeline Co.....	Consumers Power Co.....	10-30-91	B	5,500	N	I	10-01-91	Indef.
ST92-0403	Columbia Gas Transmission Corp.	Narragansett Electric Co....	10-30-91	G-S	90,000	N	I	10-02-91	Indef.
ST92-0404	Columbia Gas Transmission Corp.	Columbus Hobbs.....	10-30-91	G-S	1,900	N	I	10-10-91	Indef.
ST92-0405	Columbia Gas Transmission Corp.	Lindsey and Elliott.....	10-30-91	G-S	2,428	N	I	10-10-91	Indef.
ST92-0406	Columbia Gas Transmission Corp.	Oliver M. Roberts.....	10-30-91	G-S	992	N	I	10-10-91	Indef.
ST92-0407	Columbia Gas Transmission Corp.	City of Richmond.....	10-30-91	B	52,000	N	I	10-01-91	Indef.
ST92-0408	Superior Offshore Pipeline Co.	Norcen Explores, Inc.....	10-31-91	B	10,000	N	F	10-01-91	Indef.
ST92-0409	Questar Pipeline Co.....	Grand Valley Gas Co.....	10-31-91	G-S	45,820	N	I	10-01-91	Indef.
ST92-0410	Questar Pipeline Co.....	City of Springfield.....	10-31-91	B	10,460	N	F	10-02-91	Indef.
ST92-0411	Questar Pipeline Co.....	Grand Valley Gas Co.....	10-31-91	G-S	20,000	N	I	10-18-91	04-30-92.
ST92-0413	Valero Transmission, L.P.	Tennessee Gas Pipeline Co.	10-31-91	C	8,000	N	I	10-01-91	Indef.
ST92-0414	Texas Gas Transmission Corp.	Access energy Corp.....	10-31-91	G-S	100,000	N	I	10-17-91	02-13-92.

Docket No. ¹	Transporter/seller	Recipient	Date filed	Part 284 subpart	Est. max. daily quantity ²	Aff. Y/N	Rate schedule	Date commenced	Projected termination date
ST92-0415	Trunkline Gas Co.....	Aquila Energy Marketing Corp.	10-31-91	G-S	100,000	N	I	10-03-91	01-31-92
ST92-0416	Trunkline Gas Co.....	Vesta Energy Co.....	10-31-91	G-S	20,000	N	I	10-01-91	01-29-92
ST92-0417	Trunkline Gas Co.....	Bishop Pipeline Corp.....	10-31-91	G-S	5,000	N	F	10-01-91	01-29-92
ST92-0418	Trunkline Gas Co.....	Energy Development Corp.	10-31-91	G-S	10,000	N	I	10-01-91	01-29-92
ST92-0419	Trunkline Gas Co.....	Howell Gas Management Co.	10-31-91	G-S	20,000	N	I	10-02-91	01-30-92
ST92-0420	Trunkline Gas Co.....	Amerada Hess Corp.....	10-31-91	G-S	100,000	N	I	10-01-91	01-29-92
ST92-0421	Tennessee Gas Pipeline Co.	CNG Transmission Corp...	10-31-91	G	701,215	N	I	10-01-91	Indef.
ST92-0422	Tennessee Gas Pipeline Co.	Fina Natural Gas Co.....	10-31-91	G-S	100,000	N	I	10-01-91	01-29-92
ST92-0423	Tennessee Gas Pipeline Co.	Tejas Power Corp.....	10-31-91	G-S	103,000	N	I	10-01-91	01-29-92
ST92-0424	Tennessee Gas Pipeline Co.	Entrade Corp.....	10-31-91	G-S	1,310,000	N	I	10-01-91	01-29-92
ST92-0425	Tennessee Gas Pipeline Co.	Superior Natural Gas Corp.	10-31-91	G-S	50,000	N	I	10-01-91	01-29-92
ST92-0426	Texas Gas Transmission Corp.	Excel Intrastate Pipeline Co., Inc.	10-31-91	G-S	100,000	N	I	10-18-91	02-14-92
ST92-0427	Transok, Inc.....	KN Energy, Inc.....	10-31-91	C	50,000	N	I	10-01-91	Indef.
ST92-0428	Transok, Inc.....	Phillips Gas Pipeline Co....	10-31-91	C	20,000	N	I	10-01-91	Indef.
ST92-0429	ANR Pipeline Co.....	Michigan Consolidated Gas Co.	10-31-91	B	12,000	N	I	10-05-91	Indef.
ST92-0430	ANR Pipeline Co.....	Arkansas Louisiana Gas Co.	10-31-91	B	30,000	N	I	10-01-91	Indef.
ST92-0431	ANR Pipeline Co.....	Public Service Electric & Gas.	10-31-91	B	200,000	N	I	10-01-91	Indef.
ST92-0432	Arkansas Oklahoma Gas Corp.	Arkla Energy Resources...	10-31-91	G-HT	4,000	N	I	10-02-91	10-02-96
ST92-0433	Arkansas Oklahoma Gas Corp.	Ozark Gas Transmission System.	10-31-91	G-HT	20,000	N	I	10-01-91	10-01-96
ST92-0434	Arkansas Oklahoma Gas Corp.	Ozark Gas Transmission System.	10-31-91	G-HT	2,000	N	I	10-02-91	10-02-96
ST92-0435	Arkansas Oklahoma Gas Corp.	Ozark Gas Transmission System.	10-31-91	G-HT	5,000	N	I	10-01-91	10-01-96
ST92-0436	Arkansas Oklahoma Gas Corp.	Ozark Gas Transmission System.	10-31-91	G-HT	1,000	N	I	10-01-91	10-01-96

¹ Transportation Service converted from authority under 18 CFR 284.106, subpart B, to authority under 18 CFR 284.223(f)(1), subpart G-S.

² Notice of transactions does not constitute a determination that filings comply with commission regulations in accordance with order no. 436 (final rule and notice requesting supplemental comments, 50 FR 42,372, 10/10/85).

Estimated maximum daily volumes includes volumes reported by the filing company in MMBTU, MCF and DT.

[FR Doc. 91-28187 Filed 11-22-91; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. JD92-00928T; Texas-8 Amendment 2]

State of Texas; NGPA Determination by Jurisdictional Agency Designating Tight Formation

November 18, 1991.

Take notice that on October 29, 1991, the Railroad Commission of Texas (Texas) submitted the above-referenced notice of determination pursuant to § 271.703(c)(3) of the Commission's regulations, that the Geopressured Wilcox-Lobo Sandstone Formation (also identified in the recommended area as the Lower Wilcox Sand Interval), in Webb County, Texas, qualifies as a tight formation under section 107(b) of the Natural Gas Policy Act of 1978 (NGPA). The notice covers approximately 1740 acres in Webb County and consists of all of the following acreage:

Survey name	Acres	Portion	Abstract
City of Laredo.....	870	50	A-716
City of Laredo.....	870	49	A-1529

The Geopressured Wilcox-Lobo Sandstone Formation underlying the subject 1,740 acres (along with other adjacent acreage) was previously excluded, by Texas, from tight formation designation in the original recommendation for the Geopressured Wilcox-Lobo Sandstone Formation, designated Texas-8 by Order No. 153, issued June 10, 1981 (15 FERC ¶ 61,245).

The notice of determination also contains Texas' findings that the referenced portion of the Geopressured Wilcox-Lobo Sandstone Formation meets the requirements of the Commission's regulations set forth in 18 CFR part 271.

The application for determination is available for inspection, except for material which is confidential under 18 CFR 275.206, at the Federal Energy Regulatory Commission, 825 North

Capitol Street, NE., Washington, DC 20426. Persons objecting to the determination may file a protest, in accordance with 18 CFR 275.203 and 275.204, within 20 days after the date this notice is issued by the Commission.

Lois D. Cashell,

Secretary.

[FR Doc. 91-28185 Filed 11-22-91; 8:45 am]

BILLING CODE 6717-01-M

[Docket Nos. IN83-2-000; IN92-1-000]

Various Producer-Owned Natural Gas Processing Plants, Producers Selling Gas Processed at the Laverne and/or Mooreland Plants; Proposed Civil Penalty

November 18, 1991.

Pursuant to section 504(b)(6)(E) of the Natural Gas Policy Act of 1978, 15 U.S.C. 3414(b)(6)(E) (1988), take notice that the Commission proposes to assess civil penalties against each producer listed in the Appendix to this Notice (Listed Producer). The Commission proposes to

assess these penalties in connection with any violations of section 504(a) of the NGPA arising from charges or collections for natural gas any Listed Producer sold after December 1, 1978 to Michigan Wisconsin Pipeline Company (now ANR Pipeline Company (ANR)), or to any other purchaser, and thereafter processed at the Laverne and/or Mooreland gas processing plants in Oklahoma.

The proposed civil penalty shall be in the amount of \$5,000 for each violation that occurred no more than three years prior to the date of this notice. Each day on which a Listed Producer overcharged ANR or any other purchaser under a particular sales agreement shall constitute a separate violation by that producer.

Issuance of this notice tolls the applicability, if any, of the statute of limitations in 15 U.S.C. 3414(b)(6)(D), but is not a determination that civil penalties will be assessed against any Listed Producer.

By direction of the Commission.

Lois D. Cashell,

Secretary.

Appendix

Ace Co.

Adair Robert L.

Adams Nolan

Adler Jack P. Deceased Estate of C/O

Fink, Weinberger, Fredman Berman,

Lowell, & Fensterheim

Adobe Resources Corp.

Aftag Inc.

Amax Petroleum Corp.

Amarex Funds of Delaware Inc.

Amarex Inc.

Ambrit Energy Corp.

Amerada Hess Corp.

Anadarko Petroleum Corp.

Anadarko Production Co.

Anderson Bruce

Anr Production Co. C/O Coastal Oil & Gas Corp.

Anson Co.

Apeland D C Trustee C/O Thomas C. Carrson

Arch Oil & Gas Co.

Arco Oil & Gas Co.

Arnold Claude

Arnold John G. Trustee

Arrington J.H. Family Trust

Arrington Veneta Berry Revocable Tr

Ashland Exploration Inc.

Ashland Oil Co. Inc.

Atkinson Edward L.

Atlantic Richfield Co.

Attebury Josephine E & Joyce S Tr C

B.C.S. Natural Resources Corp.

B.R. Polk Inc.

Bagshaw John J.

Baird Doyle H.

Banowsky William

Barnes Petroleum Inc.

Barta W.J.

Bayside Petr. Corp. 84 Priv. Drig. Prgm.

Beams Minerals Co.

Beard Oil Co.

Beck Pump & Supply Inc.

Bellows Randall F.

Berg Jalmar

Berry Thomas Diggs

BFO Energy Inc.

BHP Petroleum (Americas) Inc.

BHP Petroleum Co. Inc.

Black Hawk Holding Co.

Bloomer Parker Eugene

Bluesky Oil & Gas Inc.

BNC Inc.

BO-MC Oil Corp.

Boisvert Ray

BP Exploration Inc.

Brandt Robert

Brandt Ruth Ann

Bristol Resources Corp.

Brown Leone

Brown Paul

Bucy M. Peyton

Burnett Oil Co. Inc.

Cabot Corp.

Cabot Petroleum Corp.

Calpetco III 76 C/O Silver State

Resources Corp.

Cap Ltd

Carlson Petroleum Co.

Carmen Field Ltd Partnership

Cass Deborah Humphrey

Cayman Corp.

Champlin Douglas L.

Champlin Exp Inc. 72 Oil & Gas Ptshp.

Champlin Explor Inc. Drig Ptshp 73

Champlin H. H.

Chapman Resources Corp.

Cheniere Petroleum Corp.

Chevron USA Inc.

Cheyenne Petroleum Co.

Childress Royalty Co.

Cimarron Petroleum Corp.

Cirrus Production Co.

CNG Producing Co.

Coastal Oil & Gas Corp.

Cobb Jon F.

Cobra Oil & Gas Corp.

Cochran Patricia Davis

Cohen Julius J.

Coleman Joe M.

Collet Oil Ventures Inc.

Collins J. P.

Conoco Inc.

Continental Trend Resources Inc.

Corpening Enterprises

Cottonwood Oilfield Services Inc.

Cox Edwin L.

Crawley Petroleum Corp.

D & J Oil Co. Inc. (OK)

D Andrea Joseph A.

Davis John W.

Davis W. Howard

Dayvault David M. Rev. Trust C/O

Graham Michaelis Corp.

Decalta International Corp.

Delta Petroleum Inc.

Detle Oil Corp.

Dialta International Oils Inc.

Duncan J. Walter Jr.

Duncan Raymond T.

Duncan Vincent J.

Duncan Walter Estate

Dyco Petroleum Corp.

Ed McQueen & Co. Inc.

Eigner Richard M.

E-L Paso Natural Gas Co.

Electra Energy Co. C/O Joseph I.

O'Neill, Jr.

Elliott-Hall

Ellis J. Ralph Jr.

EM Nominee Partnership Co. C/O Edp

Operating, Ltd.,

Ensource Inc.

Erickson Donald O.

Exploration Associates

Exxon Corp.

Farrar Oil Co.

Fell & Wolf Oil Co.

Fina Oil & Chemical Co.

Fischer Malinda Berry

Flag-Redfern Oil Co.

Fletcher Don E.

Fletcher Gay Trust

Foran Oil Co.

French L. R. Jr.

Fuller Thomas R.

Fulton Enterprises Inc.

G B K 72 B C/O Gadsco Inc.

Gadbois Guy Estate of

Gadbois Marcella F. Estate of

Gadsco Inc.

Gall Hortense

Getty Oil Co.

Gibson Wilbur

Godfrey Gaines L.

Goerz Gay

Goff Gene Estate

Grace Petroleum Corp.

Graham Enterprises C/O Graham-

Michaelis Corp.

Graham-Michaelis Corp.

Grahamco C/O Graham-Michaelis Corp.

Gruss Joseph S.

Gulf Oil Corp.

H A Oil & Gas Co. dba

H Huffman & Co.

Hale D. L.

Halpin Evelyn T. C/O Cornerstone Bank

NA

Halpin Robert T.

Hamon Operating Co.

Hanney John V. Trust

Hanover Development Venture 72 Ltd

Hanover Planning Co. Inc.

Harris Neva L.

Hawks Georgia Whittenburg Trust #1

Headington Oil Co.

Helmerich & Payne Inc.

Henry H. Gungoll Associates

Herrick Scott D.

Hillin Oil Co.

Hirzel Fred R. Jr. Estate C/O Carlson

Petroleum Company

Home Stake Oil & Gas Co.

Home Stake Royalty Corp.

Hondo Oil & Gas Co.
 Houser W. F. Sr. Estate
 Humphrey J. A.
 Humphrey J. A. Trustee
 Humphrey Layton A. Jr.
 Hunt H L Estate
 Hunt H. L. Mrs.
 Hunt Lyda-Lamar TR-Clark K. Hunt
 Hunt Lyda-Lamar TR-Sharron L. Hunt
 Hunt Lyda-Lamar Trust-Daniel L. Hunt
 Hunt Lyda-Lamar Trust-Lamar Hunt Jr.
 Hunt Lyda-Margaret Trusts
 Hutton Indian Wells Ergy I F Inc. 84
 Inca Oil Corp.
 Independence Drilling Program 80
 Irell Lawrence
 J M Huber Corp.
 Jackson William A.
 Jacobs Joseph F. C/O Graham-Michaelis Corp.
 James John L. Rev. Trust C/O Graham Michaelis Corp.
 Janewill Petroleum Inc.
 JCR JR. Operating Inc. C/O Joe C. Richardson, Jr.
 Jet Oil Co.
 Johnstone Colette H. Trust
 JWD III Inc.
 Kaiser-Francis Special Acct. C.
 Keener Oil Co.
 Kennedy & Mitchell Inc. C/O Harken Oil & Gas Inc.
 Kennedy Howard L.
 Kennedy Jacqueline
 Kerr-McGee Corp.
 Kirkpatrick Oil & Gas Co.
 KP/Templeton Oil & Gas I F Ltd 83
 Kreiter-Meissner-Hackbarth TR First National Bank & Trust Trustee Account #05405006
 Kridler Nina L.
 Kurtz, Patricia
 L & R Investments DBA
 Ladd Petroleum Corp.
 Lamb, Alan L.
 Lambert, Robert Benjamin
 Layne, Jack
 Leben Oil Corp.
 Lee, Billy W.
 Leroux, W.E. c/o Bank of Oklahoma
 Leroux, W.E. Trust c/o Bank of Oklahoma
 Less, John W. c/o R.B. Jones of St. Louis
 Lightning Productions Inc.
 Lignum Oil Co.
 Lobo Exploration Co.
 Logo & Ellis
 Logsdon, Bill
 Lowry, Dorothy J
 Loyal Trust 1
 Loyal Trust 2
 Loyal Trust 3
 Loyal Trust 4
 Lugaric, Thomas F.
 Lund, R.T. Oil Trust
 Lundin, E.H.
 Maher, Doris Louise Leonard
 Maple Properties Corp.
 March Oil Co.

Marlin Oil Corp.
 Matador Petroleum Corp.
 Maxus Exploration Co.
 McRae, John A.
 McCord, L.A.
 McEuen, Joe S.
 McMurtry, Wilbur E.
 Medallion Petroleum Inc.
 Mee, P.C.
 Mercer 1985A Managed Drilling Prgm
 Meridian Oil Production Inc.
 Mesa Operating Limited Partnership
 Mesa Petroleum Co.
 Meyer, David c/o Crawley Petroleum Corp.
 Michaelis, H.R. Rev. Trust
 Michaelis, W.A. Jr., Rev. Trust
 Min-Tex Oil Corp.
 Mitchell, Evelyn J.
 Mitchell, John F.
 Morey, John B.
 Morgan Petroleum Co.
 Multistate Oil Properties nv c/o Tenneco Oil Company
 Naslund, Edward
 Natomas North America Inc.
 Natural Gas Compression Corp.
 Natural Resource Management Corp.
 Nave, Joanna C. Thomas
 Neeley, Leland C.
 Ni-Gas Supply Inc.
 Ninian Oil Co.
 Noble, Sam
 Norfin Inc.
 O'Neill Duncan Mich-Wis Gas Prgm 75
 O'Neill Properties Ltd. c/o Joseph I. O'Neill Jr.
 Oehl Inc.
 Ogle Production Corp.
 Oklahoma Gas Program 75 c/o Joseph I. O'Neill
 Oklahoma Natural Gas Co.
 One Oil Co.
 Oneok Exploration Co.
 Oneok Resources Co.
 Oswego Petroleum Inc. c/o Great Western Oil & Gas
 Oxy USA Inc.
 Ozark-Mahoning Co., Oil Division
 P-E Partnership c/o Pantera Energy Co., Fisk Building
 Pacific Enterprises Royalty Company
 Packer Allen Dr. c/o Adobe Resources Corp.
 Park A.L.
 Park Arthur L. Trustee c/o The Prappas Co.
 Partnership Properties Co.
 Partridge Petroleum Corp.
 Payne W.C.
 Penny E.J.
 Peter Paul Petroleum Co.
 Petro-Lewis Corp.
 Petro-Search Exploration Corp.
 Petrojarl Inc.
 Petroleum Inc.
 Petroleum International Inc.
 Petty Amy M.
 Phillips Petroleum Co.
 Pioneer Corp.
 Pioneer Production Corp.
 Pitson Corp.

Plains Anadarko P. Ltd. Ptshp.
 Plains Anadarko SL Ltd. Ptshp.
 Plains Resources Inc.
 PNG Operating Co.
 Premier Resources Ltd.
 Prentice Napier & Green, Inc.
 Presidio Exploration Inc.
 Price Joel S. Childrens Trust
 Price Joel S. Marital Trust
 Price Virginia K.
 Prudential Group Inc.
 Prudential-Bache I Prod Ptshp VP-18
 Prudential-Bache I Prod Ptshp VP-19
 Quail Creek Petroleum
 Quinoco Consolidated Partners LP
 Quinoco Petroleum, Inc.
 Quinoco O&G I PGM 1985-1 c/o Quinoco Petroleum, Inc.
 Quinoco O&G I PGM 1985-2 c/o Quinoco Petroleum, Inc.
 Quinoco O&G I PGM 1985-3 c/o Quinoco Petroleum, Inc.
 Quinoco Oil & Gas Income Prgm 84-1 c/o Quinoco Petroleum, Inc.
 Quinoco Oil & Gas Income Prgm 84-2 c/o Quinoco Petroleum, Inc.
 Quinoco Oil & Gas Income Prgm 84-3 c/o Quinoco Petroleum, Inc.
 Rambler Oil Co.
 Ranola Oil Co.
 Resource Reserves Co.
 Resources Investment Corp.
 Rich Bros. Investments
 Ricks Ran Jr.
 Riddell Aimee Louise Estate
 Riddell John F. Estate
 Riddell John F., Jr.
 Robert R. Willhour, Inc.
 Robinson W.A.
 Rocket Oil & Gas Co.
 Roessler Linda G.
 Romano Eileen H. Trust
 Romano Sergio Childrens Trust
 Romarco, Inc.
 Sabine Oil Industries, Inc.
 Samedan Oil Corp.
 Santa Fe Braun, Inc.
 Scarth Oil & Gas Co.
 Schuebel Jane
 Schusterman Charles
 Shar-Alan Oil Co.
 Shell Oil Co.
 Shell Western E&P Inc.
 Shelton John W.
 Silvius Beatty
 Singer Joseph B. Revocable Trust
 Slawson Donald C. Oil Producer
 Smith E.E. Md
 Snellan Donald L.
 Sonat Exploration Co.
 South Timbers Ltd. Ptshp.
 Southland Royalty Co.
 Southwest Oil Industries, Inc.
 Sparks Bill J.
 SRJ Ventures
 State Energy & Investment, Inc.
 Sterling Investors Group
 Stewart J.M.
 Stowe Josephine Uri
 Sullivan R.J.
 Sullivan R.J. Trust
 T. Rex, Inc.
 Tema Oil Co.
 Temex Energy, Inc.

Templeton Energy Income Corp.
Tenneco Oil Co.
Terry Ernie B.
Texaco Oils Inc.
Texaco Producing Inc.
Texas Pacific Oil Co. Inc.
TGX Corp.
Thatcher Dorothy Riddell
Thatcher Dorothy Riddell Issues
Thomas N. Berry & Co.
Trinity Resources, Inc.
Triton Oil & Gas Corp.
Triton Producing Co.
Twin Eagle Petroleum Corp.
TXO Production Corp.
Unger Edwin H.
Unicon Producing Co.
Union Oil Co. of California
Union Pacific Resources Co.
Unit Corp.
Unit Energy Income Fund 86
Unit Four Partnership
Universal Drilling Corp.
Unocal
Uplands Resources, Inc.
Uri Joseph J.
Van Oil Co.
Vanderpool Clinton
Vanguard Oil & Gas, Inc.
Viersen Sam K.
Viersen Sam K. Jr.
Vince Allen MU 80 c/o Vince Allen & Associates, Inc.
Vintage Petroleum, Inc.
Wainoco Oil & Gas Co.
Walker Annie W. Trust #3
Walker Earl
Walker Eldon
Walker Henrietta
Walker R. Lance
Walker Robert c/o Walker Exploration
Walker W.E. Heirs c/o Lavaca Corp.
Warrior Oil Co.
Waschka Patricia H. Trust
Waschka Ronald W. Trust
Washita Production JT Venture 85-1
Weinkauff Petroleum, Inc.
Wessely Energy Co. c/o NGC Energy Company
West Timbers Ltd. Ptshp.
Western Farmers Electric Coop
Western Reserves Oil Co.
Whitaker Energy, Inc.
Whitmar Private Drlg Prgm 80-I c/o Whitmar Exploration
Wildcat Resource, Inc. c/o Carlson Petroleum Co.
William Graham, Inc. c/o Graham Michaelis Corp.
Williams Thomas P.
Williford Richard A. c/o Williford Energy Company
Witten Richard
Woodward Iodine Corp.
Wyant I.A.
Yale Oil Assn., Inc.
Yinger Jack L. Rev. Trust
Yucca Petroleum Co.

[FR Doc. 91-28186 Filed 11-22-91; 8:45 am]
BILLING CODE 6717-01-M

[Docket No. TM92-7-20-000]

Algonquin Gas Transmission Company; Proposed Changes in FERC Gas Tariff

November 18, 1991.

Take notice that Algonquin Gas Transmission Company ("Algonquin") on November 14, 1991, tendered for filing proposed changes in its FERC Gas Tariff, Third Revised Volume No. 1, as set forth in the following revised tariff sheets:

Proposed To Be Effective November 1, 1991

6 Rev Sheet No. 41

6 Rev Sheet No. 42

Algonquin states that the revised tariff sheets are being filed to flow through changes in Texas Eastern Transmission corporation's Rate Schedules SS-2 and SS-3, which underlie Algonquin's Rate Schedules STB and SS-III. Pursuant to section 10 of Rate Schedule STB and Section 9 of Rate Schedule SS-III in Algonquin's FERC Gas Tariff, Third Revised Volume No. 1, Algonquin is hereby filing the above sheets to track the latest changes filed by Texas Eastern on October 23, 1991 to be effective November 1, 1991.

Algonquin also states that pursuant to sections 10.3 and 9.3 of Rate Schedules STB and SS-III, respectively, the proposed effective date for the listed revised tariff sheets is November 1, 1991.

Algonquin further states that the effect of the filed tariff sheets is to decrease the STB and SS-III space charges by 0.02¢ per MMBtu and to increase the injection charges by 0.10¢ per MMBtu. Also, the STB withdrawal rate is increased by \$0.01¢ per MMBtu and the SS-III FDDQ and Non-FDDQ withdrawal rates are increased by 0.02¢ per MMBtu.

Algonquin notes that copies of this filing were served upon each affected party and interested state commissions.

Any person desiring to be heard or to protest said filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, DC 20426, in accordance with §§ 385.214 and 385.211 of the Commission's Rules and Regulations. All such motions or protests should be filed on or before November 25, 1991. Protests will be considered by the Commission in determining the appropriate action to be taken but will not serve to make protestants parties to the proceeding. Any person wishing to become a party

must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection in the Public Reference Room.

Lois D. Cashell,
Secretary.

[FR Doc. 91-28191 Filed 11-22-91; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. IN92-2-000]

Amoco Production Co. and Oryx Energy Co.; Order Setting Matter for Hearing

Issued November 18, 1991.

Amoco Production Company (Amoco) and Oryx Energy Company (Oryx)¹ may have engaged in and may be engaging in acts and practices that violate the Natural Gas Act (NGA), 15 U.S.C. 717 *et seq.* (1988), and the Natural Gas Policy Act of 1978 (NGPA), 15 U.S.C. 3301 *et seq.*, and the Commission's regulations thereunder.²

Oryx and Amoco have made and may be making first sales of natural gas to ANR Pipeline Company (ANR) under various contracts or rate schedules at numerous field delivery points. The gas sales contracts may have a single ceiling price or an assortment of prices, including prices allowed under sections 102, 103, 104, 106 and 108 of the NGPA.³

¹ Oryx is successor-in-interest to Sun Company, Inc. and Sun Exploration and Production Company. The name Oryx will be used in this order to refer to all three companies.

² The Enforcement Section of the Office of the General Counsel has conducted an investigation into certain sales of natural gas from the Laverne and Woodward areas of Oklahoma under the Commission's Rules Relating to Investigations, 18 CFR Part 1b (1991), and pursuant to the Commission's October 6, 1982 Order Directing Investigation, 21 FERC ¶61,015 (1982).

³ Oryx made wellhead sales of gas to ANR, *inter alia*, under FERC rate schedule nos. 1, 86, 130, 146, 148, 295, 365, 392, 393, 443, 481, 501, 510, 528, 557, 558, 578, 580, 618, 683, 696 and 751. Under the terms of the pertinent gas purchase contracts, as amended, ANR paid Oryx the maximum lawful price (MLP) permitted under the NGPA for gas sales after the NGPA became effective. Amoco made wellhead sales of gas to ANR, *inter alia*, under FERC rate schedule nos. 238, 256, 273, 330, 331, 339, 342, 343, 344, 345, 349, 350, 351, 392, 399, 403, 448, 459, 548, 577, 613, 624, 654, 665, 722, 803, 804 and 805. Under the terms of the gas purchase contracts, as amended, ANR paid Amoco the applicable MLP for the gas.

Either explicitly or implicitly under the contracts, ANR allows producers to use the gas in gas processing plant operations and to extract the natural gas liquids. The transactions at issue in this proceeding involve processing operations at the Laverne Gas Products Recovery Plant (Laverne plant), operated by Oryx, and the Mooreland Gas Products Recovery Plant (Mooreland plant), operated by Amoco. Both plants are located in Oklahoma.

Under the gas purchase contracts, Oryx and Amoco constructed processing plants and processed the gas they sold in accordance with processing agreements with ANR. Plant operations connected with the processing of natural gas normally reduce the volume of natural gas (PVR) and/or the heating content of the gas (PCR). These reductions are attributable to shrinkage, use of gas as plant fuel and incidental losses. For the purposes of this order, we sometimes refer to both reductions generically as PVR. In order to compensate ANR for PVR and PCR lost in the Laverne and Mooreland plants, the processing agreements between the producers and ANR divide the gas into two categories, "Base Quality," or gas with a heating value of 1000 Btu per cubic foot, and "Excess Quality," or gas with a heating value in excess of 1000 Btu per cubic foot.

For "Base Quality" gas lost in processing, Amoco and Oryx pay an amount equal to the weighted average price paid or payable by ANR for "Base Quality" gas. For each Mcf of "Excess Quality" gas lost, Amoco and Oryx pay two amounts. First, they pay the "Base Quality" amount. They also pay an amount equal to the weighted average price paid or payable by ANR for the "Excess Quality" component of gas gathered into the system, but such compensation for the "Excess Quality" component is not to exceed $\frac{1}{100}$ cent per cubic foot.⁴

Section 4 of the NGA, 15 U.S.C. 717c, prohibits natural gas companies from charging more than the just and reasonable rate set by the Commission.

⁴ The producers' obligations to contribute toward PVR are based on their percentage of ownership in each plant. For Amoco and Oryx, plant ownership is based on three discrete elements: (1) Gas processed at those plants as a result of that producer's own wellhead sales; (2) gas processed for the producer at those plants as a result of processing rights associated with other producers' wellhead sales, acquired through assignment; and (3) a pro rata distribution, through ANR, of other producers' unexercised processing rights. Accordingly, Amoco and Oryx have had an obligation to compensate ANR for PVR associated with their wellhead gas sales to ANR under element (1) above and for additional processing rights they have acquired under elements (2) and (3) above.

Section 504(a)(1) of the NGPA, 15 U.S.C. 3424(a)(1), provides that it is "unlawful . . . to sell natural gas at a first sale price in excess of any applicable maximum lawful price under this Act." The weighted average maximum lawful price (MLP) that the producers charged for their gas at the wellhead may be substantially more than the $\frac{1}{100}$ cent per cubic foot (10 cents per Mcf) ceiling on payment for "Excess Quality" gas lost in processing. If the wellhead sale and the PVR/PCR compensation together are integral parts of a single "first sale," an issue to be decided in this proceeding, the $\frac{1}{100}$ cent per cubic foot ceiling on compensation for the "Excess Quality" component of the gas may have caused Amoco and Oryx to receive a first sale price exceeding the applicable just and reasonable price (for gas subject to the Commission's jurisdiction under NGA section 4) and the applicable MLP.⁵

During the investigation, Amoco and Oryx denied that their wellhead sales and PVR/PCR compensation were integral parts of single "first sales" and denied that their activities violated the NGA, NGPA, or any statute or regulation that the Commission administers.

The Commission neither makes findings of fact nor reaches conclusions of law with regard to the producers' alleged acts and practices described

⁵ The economic effect of the PVR/PCR compensation formula when viewed as an integral part of a single first sale is demonstrated by the following hypothetical example:

Assume a wellhead sale of 1000 Mcf of gas with a heating value of 1200 Btu per cubic foot at a maximum lawful price of \$2.00 per MMBtu. After adjustment for Btu content (1000 Mcf $\times$ 1.2 MMBtu/Mcf = 1200 MMBtu), the gross amount paid to the first seller at the wellhead is \$2400 (1200 MMBtu $\times$ \$2.00).

Assume also that 100 Mcf of PVR and 200 Btu/cf of PCR occur during processing of the gas for seller's interest, and that after processing, 900 Mcf of gas with a heating value of 1000 Btu/cf is returned to the buyer (900 MMBtu of gas with an MLP of \$2.00).

Under the processing agreements for the Laverne and Mooreland plants, the compensation to the buyer for PCR and PVR in the plants is as follows:

For the "excess quality" component of the gas: 1000 Mcf $\times$.2 MMBtu/Mcf (PCR) = 200 MMBtu of PCR 200 MMBtu $\times$ \$.0001/Mcf (contractual ceiling price) = \$0.02

For "base quality" gas: 100 Mcf (PVR) $\times$ 1 MMBtu/Mcf $\times$ \$2.00 (MLP/MMBtu) = \$200.00

The total PVR/PCR compensation for plant loss ("base quality" + "excess quality") is \$200.02. The net price, per MMBtu, to the buyer is \$2.199.98 (\$2400.00 sale proceeds less \$200.02 total PVR/PCR compensation) divided by 900 MMBtu (received at plant tailgate), i.e. about \$2.44/MMBtu. This is 44 cents more than the MLP.

The figures used in this example are for convenience only and the 44 cent difference between the price collected and the MLP does not necessarily approximate any actual amount, per MMBtu. Amoco and Oryx may have collected in excess of the MLP.

above. However, Amoco and Oryx may now be selling and may have sold natural gas to ANR at prices in excess of the applicable just and reasonable prices under the NGA, in violation of NGA section 4, and at prices in excess of the applicable MLPs, in violation of the relevant provisions of Title I of the NGPA. These alleged violations may have occurred with respect to gas that Amoco or Oryx produced and (1) had processed for their own accounts, or (2) was processed for other producers' accounts pursuant to the assignment or pro rata distribution of processing rights.⁶

Therefore, the Commission finds that good cause exists for the Commission to determine whether Amoco and Oryx violated and are violating the foregoing provisions or any other laws or regulations that the Commission administers, as a result of the acts and practices that are alleged in this order. Good cause also exists for the Commission to determine whether appropriate remedies should be imposed if the Commission determines that any violations have occurred or are occurring.

We are dividing this proceeding into phases. In the first phase, the presiding judge will issue an initial decision on whether Amoco's or Oryx's actions violated or are violating the NGA, the NGPA, or the Commission's regulations. Given the interest all parties have in determining quickly whether or not violations have occurred or are occurring, we are directing the presiding judge to issue the initial decision in the first phase by September 15, 1992. This schedule should allow the first phase to be conducted expeditiously, while ensuring sufficient time for all participants to develop their positions fully.

If we determine that Amoco or Oryx has violated or is violating the NGA, the NGPA or Commission regulations thereunder, the presiding judge will conduct a hearing in a second phase of this proceeding to consider what remedies, if any, are appropriate.

The Commission has already issued a notice of proposed civil penalty under NGPA section 504(b)(6)(E) to Oryx,⁷ and is issuing a notice of proposed civil penalty to Amoco concurrently with the issuance of this order. Issuance of the

⁶ In another order issued today in the IN83-2-000 investigative docket, we are directing Amoco and Oryx to provide information to the Commission concerning sales of gas, to any purchasers other than ANR, which was processed at the Laverne or Mooreland plants under PVR/PCR compensation practices similar to those at issue here.

⁷ 45 FERC ¶ 61,448 (1988).

notices of proposed penalty tolls the applicability, if any, of the statute of limitations in NGPA section 504(b)(6)(D), but is not a determination that civil penalties will be assessed. The Commission reserves authority to assess civil penalties against Amoco or Oryx, as appropriate, based upon the record developed in this docket, and does not intend that the administrative law judge consider whether civil penalties should be assessed in this matter.

The Commission Orders:

(A) Pursuant to section 18 of the NGA, 15 U.S.C. 717p, section 501 of the NGPA, 15 U.S.C. § 3411, and Subpart E of the Commission's Rules of Practice and Procedure, 18 C.F.R. Part 385, Subpart E (1991), this matter is set for hearing consistent with the provisions of this order. Enforcement staff and ANR shall be participants in this proceeding.

(B) A Presiding Administrative Law Judge, to be designated by the Chief Administrative Law Judge for that purpose pursuant to 18 CFR 375.304, shall convene a prehearing conference in this proceeding. The prehearing conference shall be held within 30 days after the date of issuance of this order, in a hearing or conference room of the Federal Energy Regulatory Commission, 810 First St., NE., Washington, DC 20426. The Presiding Judge is authorized to establish and change any procedural dates necessary for the hearing and to rule on motions, all as provided for in the Commission's rules, 18 CFR part 385.

(C) The Presiding Judge shall conduct all hearings pursuant to Rule 501, *et seq.*, of the Commission's rules, 18 C.F.R. 385.501, *et seq.*, and has all authority delegated by Rule 504 of the Commission's rules, 18 CFR § 385.504.

(D) This proceeding shall be phased. In the first phase, the Presiding Judge shall determine, based on the evidence introduced into the record, (1) whether respondents have violated or are violating section 4 of the NGA, section 504(a)(1) of the NGPA, or any other law or regulation that the Commission administers, as a result of the acts and practices alleged in this order; and (2) if any such violations have occurred, their extent and duration. The Presiding Judge shall issue an initial decision in the first phase, which decision shall be subject to review by the Commission pursuant to Rule 711. The Presiding Judge shall issue this initial decision by September 15, 1992.

(E) If the Commission finds violations in the first phase, the Presiding Judge shall conduct a second phase. In a second phase, the Presiding Judge shall determine whether the Commission should order any retrospective or

prospective remedies for such violations, including, but not limited to: (1) Requiring Amoco and/or Oryx to cease and desist from all future violations; and (2) requiring Amoco and/or Oryx to refund all revenues unlawfully collected, together with interest computed under 18 CFR 154.102(c). The Presiding Judge shall not consider the assessment of civil penalties. The Presiding Judge shall issue an initial decision in a second phase, which decision shall be subject to review by the Commission pursuant to Rule 711.

(F) Within 30 days from the date of this order, Amoco and Oryx each shall provide under oath to the Commission, for the record in this proceeding, the following information and documents:

(1) Copies of all agreements between the owners of the Laverne and Mooreland plants, and all amendments to those agreements, relating to plant ownership, the assignment of processing rights and/or the calculation of PVR/PCR compensation;

(2) Copies of all gas sales agreements, and amendments to those agreements, between the producer and ANR (or its predecessor) for gas that was processed at the Laverne or Mooreland plants; and

(3) Copies of all processing agreements, and amendments to those agreements, between the producer and ANR for gas processed at the Laverne or Mooreland plants.

(G) ANR shall file with the Commission, within 30 days of the date of this order, its calculation of any overcharges it believes Amoco and Oryx collected from ANR for natural gas that was processed at the Laverne and/or Mooreland plants. ANR shall fully describe the methodology it uses for the calculation. In the calculation for each producer, ANR shall differentiate between overcharges for gas the producer sold that was (1) processed for the producer's own account, (2) processed for another producer's account through an assignment of processing rights, and (3) processed for another producer's account through an allocation or distribution of unexercised processing rights. ANR shall apply interest to the amount of overcharges it calculates, pursuant to § 154.103(c) of the Commission's regulations, 18 CFR 154.103(c). Within 30 days of the date of this order, ANR shall serve on each producer and the Enforcement staff a copy of its calculation for that producer.

(H) Amoco and Oryx each shall file with the Commission, within 30 days of receiving ANR's calculation a response addressing the mathematical accuracy of ANR's calculation, notwithstanding any legal argument or position the

respondent may take with respect to the calculation. In their responses, Amoco and Oryx also shall each indicate the extent to which any overcharges ANR calculated applied to gas the producer sold that was (1) processed for its own account, (2) processed for another producer's account through an assignment of processing rights, and (3) processed for another producer's account through an allocation or distribution of unexercised processing rights. Within 30 days of the date of receiving ANR's calculation, each respondent shall also serve on ANR and the Enforcement staff a copy of its response.

(I) Motions to intervene shall be filed no later than 15 days after the date of this order. Answers to a motion to intervene shall be filed within 10 days after the date that the motion is filed.

By the Commission.

Lois D. Cashell,
Secretary.

[FR Doc. 91-28189 Filed 11-22-91; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. ER91-649-000]

Duke Power Co.; Order Noting Interventions, Deeming Phase I Rates Withdrawn as Moot, Accepting for Filing and Suspending Phase II Rates, Establishing Hearing Procedures, and Announcing Policy Concerning Filing Dates for Electric Rate Filings

Issued November 18, 1991.

Background

On September 19, 1991, as completed on October 2, 1991, Duke Power Company (Duke) tendered for filing a proposed increase in firm power rates to eleven wholesale customers. Duke proposed a two-phase rate increase. The first step would increase revenues by approximately \$3.2 million (Phase I rates). The second step would increase revenues by an additional approximately \$1.5 million (Phase II rates). The combined increase from the two steps would increase total annual revenues by approximately \$4.8 million.

Duke requests an effective date of November 19, 1991 for both the Phase I and Phase II rates. Duke states, however, that it does not oppose a five-month suspension of its Phase II rates, as long as its Phase I rates are suspended for one day.

Notice of Duke's September 19, 1991 and October 2, 1991 submittals were published in the *Federal Register*,¹ with

¹ 56 FR 49,886 (1991); 56 FR 58,054 (1991).

comments due on or before October 9, 1991 and November 15, 1991, respectively.

Interventions

On October 1, 1991, Lockhart Power Company (Lockhart) filed a motion to intervene. Lockhart states that it is a customer of Duke, that the increases sought by Duke are substantial and may be unjust and unreasonable, and that it will be directly affected by the outcome of the case. However, Lockhart did not raise any substantive issues.

On October 7, 1991, a group of Duke's municipal customers (Municipals)² filed a motion to intervene. The Municipals state that Duke's proposed rate of return on equity of 13.25 percent is excessive. The Municipals argue that, under the Commission's West Texas policy,³ a five-month suspension of the Phase II rates is required. However, they do not object to a one-day suspension of the Phase I rates.⁴ The Municipals also state that they reserve the right to request the initiation of price squeeze procedures pending decisions by the North Carolina Utilities Commission and South Carolina Public Service Commission.

On October 22, 1991, Duke filed an answer in response to the Municipals' motion to intervene. Duke does not oppose the Municipals' intervention.

Discussion

Under Rule 214 of the Commission's Rules of Practice and Procedure,⁵ the timely, unopposed motions to intervene of Lockhart and the Municipals serve to make them parties to this proceeding.

Duke seeks approval of a two-phase rate increase. For the Phase I rates, Duke seeks only a one-day suspension. For the Phase II rates, Duke does not oppose a five-month suspension. Duke contends that each of the two steps should be separately evaluated in determining the proper suspension period. Notwithstanding Duke's arguments to the contrary, the

Commission's regulations provide that, when a utility files a phased rate increase, the Commission will determine the appropriate suspension period based on the total increase requested in all phases.⁶

Our preliminary analysis of Duke's proposed Phase II rates, which reflect both the Phase I rate increase and the Phase II rate increase, indicates that the rates have not been shown to be just and reasonable, and may be unjust, unreasonable, unduly discriminatory or preferential, or otherwise unlawful. Accordingly, we shall accept Duke's proposed Phase II rates for filing, suspend them and set them for hearing as ordered below.

In West Texas Utilities Company, 18 FERC ¶ 61,189 (1982), we explained that where our preliminary review indicates that proposed rates may be unjust and unreasonable, and may be substantially excessive, as defined in West Texas, we would generally impose a maximum suspension. Since our preliminary analysis indicates that the proposed rates may produce substantially excessive revenues, we will suspend the proposed rates for five months.

Accordingly, we will accept Duke's proposed Phase II rates for filing, suspend them for five months from Duke's requested effective date of November 19, 1991, to become effective, subject to refund, on April 19, 1992, and set them for hearing.⁷

In addition, in accordance with the Commission's policy and practice established in Arkansas Power and Light Company⁸ as further explained in Virginia Electric and Power Company,⁹ we shall phase the price squeeze issue raised by the Municipals.

Policy Concerning Filing Dates for Electric Rate Filings

With respect to the appropriate effective date, we note that Duke's original filing was tendered on September 19, 1991, but that an amendment was filed on October 2, 1991. We take this opportunity to remind utilities that filings are not complete and a filing date cannot be established under our regulations until all supporting

materials that are required to be submitted are submitted,¹⁰ and the Commission here announces that, for all rate filings made after thirty days after publication of this order in the Federal Register, the Commission will consider amendment or supplemental filing filed after a utility's initial filing—whether submitted *sua sponte* or not—to establish a new filing date for the filing in question.¹¹

The Commission orders:

(A) Duke's proposed Phase II rates are hereby accepted for filing and are suspended for five months, to become effective on April 19, 1992, subject to refund.

(B) Pursuant to the authority contained in and subject to the jurisdiction conferred upon the Federal Energy Regulatory Commission by section 402(a) of the Department of Energy Organization Act and by the Federal Power Act, particularly sections 205 and 206 thereof, and pursuant to the Commission's Rules of Practice and Procedure and the regulations under the Federal Power Act (18 CFR, chapter I), a public hearing shall be held concerning the justness and reasonableness of Duke's proposed Phase II rates.

(C) The Commission trial staff is hereby directed to file top sheets within fifteen (15) days of the date of this order.

(D) A presiding administrative law judge, to be designated by the Chief Administrative Law Judge, shall convene a conference in this proceeding to be held within approximately fifteen (15) days after service of staff top sheets, in a hearing room of the Federal Energy Regulatory Commission, 810 First Street, N.E., Washington, DC 20426. The presiding judge is authorized to establish procedural dates and to rule on all motions (except motions to dismiss) as provided for in the Commission's Rules of Practice and Procedure.

(E) The Commission hereby orders initiation of price squeeze procedures and further orders that this proceeding be phased so that the price squeeze

² The Municipals include: the Public Works Commissions of Due West and Greenwood, South Carolina; the Seneca Light and Water Board of Seneca, South Carolina; the Town of Prosperity, South Carolina; the City of Union, South Carolina; the Cities of Concord and Rings Mountain, North Carolina; the Town of Dallas, North Carolina; and the Public Works Department of the Town of Forest City, North Carolina.

³ See West Texas Utilities Company, 18 FERC ¶ 61,189 (1982).

⁴ Additional issues identified by the Municipals include: (a) nuclear decommissioning expenses; (b) an improper capital structure; (c) inclusion of plant held for future use for which Duke has no definite plan; (d) improper allocation to wholesale service of certain demand-side management costs; (e) failure to deduct operating reserves from rate base; and (f) rate design.

⁵ 18 CFR 385.214 (1991).

⁶ See 18 CFR 2.18(a) (1991); see also Orange and Rockland Utilities, Inc., 46 FERC ¶ 61,036 at 61,216 (1989); Phased Electric Rate Filings; Statement of Policy, FERC Stats. & Regs. Regulations Preambles 1986-1990 ¶ 30,721 at 30,472 (1986). There are some exceptions, e.g., if the phasing is part of a rate moderation plan. Duke has not addressed Section 2.18 of the Commission's regulations. Moreover, Duke does not qualify for any of the exceptions.

⁷ Consistent with this determination, Duke's proposed Phase I rates will be deemed withdrawn as moot.

⁸ 8 FERC ¶ 61,131 (1979).

⁹ 56 FERC ¶ 61,455 (1991).

¹⁰ See 18 CFR § 35.2(c) (1991). The filing date is important because, absent waiver, a rate may be made effective no earlier than 60 days after the filing and no later than 120 days after the filing. 16 U.S.C. § 824d(d) (1988); 18 CFR § 35.3(a) (1991).

¹¹ We note that, as a matter of discretion, we are not applying this policy in the instant case. That is because we have not before indicated that this was an approach we intended to follow. In contrast, in Central Maine Power Company, 56 FERC ¶ 61,200, order on reh'g, 57 FERC ¶ 61,083 (1991), the policy that we announced was not a new policy and, in fact, was a policy already provided for in both the Federal Power Act and our regulations, as well as in other, prior cases. Consequently, in that case we applied it to Central Maine's filings.

procedures begin after issuance of a Commission opinion establishing the rate which, but for consideration of price squeeze, would be just and reasonable. The presiding judge may modify this schedule for good cause. The price squeeze portion of this case shall be governed by the procedures set forth in section 2.17 of the Commission's regulations, 18 CFR 2.17 (1991), as they may be modified prior to the initiation of the price squeeze phase of this proceeding, as discussed in the body of this order.

(F) Duke is hereby advised of the rate schedule designations shown on the Attachment.

(G) The Secretary shall promptly publish a copy of this order in the Federal Register.

By the Commission.

Lois D. Cashell,
Secretary.

Attachment

**DUKE POWER COMPANY—DOCKET NO.
ER91-649-000**

[Rate Schedule Designations]

Supplement No.	Super-sedes supplement No.	To rate schedule No.	Other party
(1) 35	32	245	Concord, N.C.
(2) 30	29	254	Dallas, N.C.
(3) 40	38	237	Forest City, N.C.
(4) 33	32	260	Kings Mountain, N.C.
(5) 28	27	259	Clemson University, S.C.
(6) 23	22	269	Due West, S.C.
(7) 54	51	250	Commissioner of Public Works, Greenwood, S.C.
(8) 33	32	242	Prosperity, S.C.
(9) 25	24	263	Seneca, S.C.
(10) 42	38	252	Lockhart Power Company, S.C.
(11) 29	28	262	South Carolina Electric & Gas Company

[FR Doc. 91-28190 Filed 11-22-91; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. TM92-5-4-000]

**Granite State Gas Transmission, Inc.;
Proposed Changes in Rates**

November 18, 1991.

Take notice that on November 12, 1991, Granite State Gas Transmission, Inc. (Granite State) 300 Friberg Parkway, Westborough, Massachusetts 01581 tendered for filing Eighth Revised Sheet No. 25 in its FERC Gas Tariff, Second Revised Volume No. 1, containing changes in rates for effectiveness on November 1, 1991.

According to Granite State, it provides a storage service for Bay State Gas Company under its Rate Schedule GSS with storage capacity provided in a facility operated by CNG Transmission Corporation (CNG). It is further stated that Granite State's Rate Schedule GSS tracks changes made by CNG under its Rate Schedule GSS pursuant to which Granite State obtains storage capacity from CNG.

Granite State further states that on October 1, 1991, in Docket No. TM92-2-22-000, CNG filed Eighth Revised Sheet No. 34 in its FERC Gas Tariff, First Revised Volume No. 1, revising the Injection Charge in its Rate Schedule GSS, effective November 1, 1991. According to Granite State, its filing tracks in its Rate Schedule GSS the change made by CNG in its rates for Rate Schedule GSS service.

Granite State states that copies of its filing were served on Bay State Gas Company and the regulatory commissions of the states of Maine, Massachusetts and New Hampshire.

Any person desiring to be heard or to protest said filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, DC 20426, in accordance with Sections 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214). All such motions or protests should be filed on or before November 25, 1991. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Lois D. Cashell,
Secretary.

[FR Doc. 91-28192 Filed 11-22-91; 8:45 am]

BILLING CODE 6717-01-M

[Docket Nos. RF91-143-006 and RP91-231-001]

Great Lakes Gas Transmission Limited Partnership; Proposed Changes in FERC Gas Tariff

November 18, 1991.

Take notice that Great Lakes Gas Transmission Limited Partnership (Great Lakes) filed on November 15, 1991 revised tariff sheets to be effective November 1, 1991, subject to refund, in compliance with the Commission's October 31, 1991 Opinion and Order Determining Cost Allocation and Denying Rehearing in Docket No. RP91-143-000 and the Commission's October 31, 1991 Order on Motion to Have Suspended Tariff Sheets Go Into Effect, Redocketing Filing, and Consolidating Dockets in Dockets Nos. RP91-143-000 and RP91 231-000. Great Lakes states that the revised tariff sheets provided for an annual rate increase for Great Lakes' jurisdictional transportation services.

Great Lakes states that the revised tariff sheets use an incremental ratemaking methodology (including an incremental Transporter's Use percentage) for its increased firm transportation services to TransCanada PipeLines Limited and to Northern Minnesota Utilities, and a rolled-in ratemaking methodology for its new service to Southeastern Michigan Gas Company. Great Lakes states that the revised tariff sheets utilize the cost of service and *ad valorem* taxes filed on June 14, 1991 and accepted by the Commission on September 23, 1991 in Docket No. RP91-143-000. Great Lakes also states that because it is complying with the Commission's October 31, 1991 orders in Dockets Nos. RP91-143 and RP91-231 as regards the ratemaking methodology issues in the filed tariff sheets, it should not bear any risk of underrecovery of its just and reasonable cost of service if on rehearing of the October 31, 1991 orders another ratemaking methodology is authorized by the Commission.

Any person desiring to protest said filing should file a protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, DC 20426, in accordance with Rule 211 of the Commission's Rules of Practice and Procedure 18 CFR 385.211. All such protests should be filed on or before November 25, 1991. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Copies of this filing are on file with the

Commission and are available for public inspection.

Lois D. Cashell,

Secretary.

[FR Doc. 91-28193 Filed 11-22-91; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. TQ92-4-25-000]

Mississippi River Transmission Corp.; Rate Change Filing

November 18, 1991.

Take notice that on November 12, 1991 Mississippi River Transmission Corporation (MRT) tendered for filing Sixty-Ninth Revised Sheet No. 4, and Twenty-Eighth Sheet No. 4.1 to its FERC Gas Tariff, Second Revised Volume No. 1, to be effective November 13, 1991. MRT states that the purpose of the instant filing is to reflect an out-of-cycle purchase gas cost adjustment (PGA).

MRT states that during November, 1991 its service areas have experienced severe abnormal weather conditions with record low temperatures resulting in unanticipated and unforeseeable increases in prices related to MRT's spot market and indexed purchases for system supply. MRT states that the effect of such increases is that the current cost of gas on which MRT's November 1 rates were predicated are no longer reflective of gas purchase costs MRT will incur during the remainder of this current PGA period.

MRT states that Sixty-Ninth Revised Sheet No. 4 and Twenty-Eighth Revised Sheet No. 4.1 to be effective November 13, 1991, reflect an increase of 4.20 cents per MMBtu in the commodity cost of purchased gas from PGA rates filed to be effective November 1, 1991. If made effective as proposed, these tariff sheets will be in effect for the limited period of November 13 through November 30, 1991.

MRT states that a copy of the filing has been mailed to each of MRT's jurisdictional sales customers and to the State Commissions of Arkansas, Missouri, and Illinois.

Any person desiring to be heard or to protest said filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, DC 20426, in accordance with 18 CFR 385.214 and 385.211 of the Commission's Rules of Practice and Procedure. All such motions or protests should be filed on or before November 25, 1991. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding.

Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection in the public reference room.

Lois D. Cashell,

Secretary.

[FR Doc. 91-28194 Filed 11-22-91; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. PR92-2-000]

Phillips Natural Gas Co.; Petition for Rate Approval

November 18, 1991.

Take notice that on November 6, 1991, Phillips Natural Gas Company (PNG) filed pursuant to § 284.123(b)(2) of the Commission's regulations, a petition for rate approval requesting that the Commission approve as fair and equitable a maximum rate of \$0.2522 per MMBtu plus 1.11% for fuel allowance for transportation of natural gas under section 311(a)(2) of the Natural Gas Policy Act of 1978 (NGPA).

PNG states that it is authorized to do business in the State of Texas and is regulated by the Railroad Commission of Texas. PNG also states that, as a "Hinshaw" intrastate pipeline company, it is not subject to the jurisdiction of the Commission by reason of section (1)(c) of the Natural Gas Act (NGA) except as to interstate transactions permitted under a limited blanket certificate of public convenience and necessity issued by the Commission pursuant to 18 CFR 284.224 in Docket No. CP87-247-000, 43 FERC ¶62,049 (April 14, 1988). PNG states that such certificate authorizes it to engage in the sale, transportation, or assignment of natural gas that is subject to the Commission's jurisdiction under the NGA to the same extent and in the same manner that intrastate pipelines are authorized to engage in such activities by subparts C, D, and E of Part 284 of the Commission's regulations. PNG states that it owns and operates a "Hinshaw" intrastate natural gas pipeline of 30-inch diameter and approximately 347 miles long named the "Texas Border Pipeline." PNG's previous maximum fair and equitable rate for Section 311 transportation services performed on the Texas Border Pipeline System of \$0.28 per MMBtu was approved by the Commission in the September 29, 1989, Letter Order issued in Docket Nos. ST89-481-000, et al. (48 FERC ¶61,420).

Pursuant to § 284.123(b)(2)(ii), if the Commission does not act within 150 days of the filing date, the rate will be deemed to be fair and equitable and not

in excess of an amount which interstate pipelines would be permitted to charge for similar transportation service. The Commission may, prior to the expiration of the 150-day period, extend the time for action or institute a proceeding to afford parties an opportunity for written comments and for the oral presentation of views, data and arguments.

Any person desiring to participate in this rate proceeding must file a motion to intervene in accordance with §§ 385.211 and 385.214 of the Commission's Rules of Practice and Procedures. All motions must be filed with the Secretary of the Commission on or before December 9, 1991. The petition for rate approval is on file with the Commission and is available for public inspection.

Lois D. Cashell,

Secretary.

[FR Doc. 91-28195 Filed 11-22-91; 8:45 am]

BILLING CODE 6717-01-M

Office of Fossil Energy

[FE Docket No. 91-65-NG]

Delhi Gas Pipeline Corp.; Order Granting Blanket Authorization to Export Natural Gas to Mexico

AGENCY: Department of Energy, Office of Fossil Energy.

ACTION: Notice of order granting blanket authorization to export natural gas.

SUMMARY: The Office of Fossil Energy of the Department of Energy gives notice that it has issued an order granting Delhi Gas Pipeline Corporation blanket authorization to export to Mexico up to 73 Bcf of natural gas over a two-year period beginning with the date of first delivery. A copy of this order is available for inspection and copying in the Office of Fuels Programs Docket Room, room 3F-056 at the above address. The docket room is open between the hours of 8 a.m. and 4:30 p.m., Monday through Friday, except Federal holidays.

Issued in Washington, DC on November 15, 1991.

Clifford P. Tomaszewski,

Acting Deputy Assistant Secretary for Fuels Programs, Office of Fossil Energy.

[FR Doc. 91-28270 Filed 11-22-91; 8:45 am]

BILLING CODE 6450-01-M

[FE Docket No. 91-67-NG]

**Kimball/Trippe Energy Associates;
Order Granting Authorization to
Import and Export Natural Gas and
Liquefied Natural Gas**

AGENCY: Department of Energy, Office of Fossil Energy.

ACTION: Notice of an order granting blanket authorization to import and export natural gas, including liquefied natural gas (LNG).

SUMMARY: The Office of Fossil Energy of the Department of Energy gives notice that it has issued an order granting Kimball/Trippe Energy Associates blanket authorization to import and export up to 50 Bcf of natural gas, including LNG, over a two-year period commencing with the date of first import or export.

A copy of this order is available for inspection and copying in the Office of Fuels Programs Docket Room 3F-056, Forrestal Building, 1000 Independence Avenue, SW., Washington, DC 20585, (202) 586-9478. The docket room is open between the hours of 8 a.m. and 4:30 p.m., Monday through Friday, except Federal holidays.

Issued in Washington, DC, November 18, 1991.

Clifford P. Tomaszewski,

Acting Deputy Assistant Secretary for Fuels Programs, Office of Fossil Energy.

[FR Doc. 91-28271 Filed 11-22-91; 8:45 am]

BILLING CODE 6450-01-M

[FE Docket No. 91-86-NG]

**MASSPOWER; Application to Import
and Export Natural Gas Including LNG
From and to Canada**

AGENCY: Department of Energy, Office of Fossil Energy.

ACTION: Notice of an application for blanket authorization to import and export natural gas, including LNG, from and to Canada.

SUMMARY: The Office of Fossil Energy (FE) of the Department of Energy (DOE) gives notice of receipt on October 16, 1991, of an application filed by MASSPOWER for blanket authorization to import and export up to 20 billion cubic feet (Bcf) of natural gas, including liquefied natural gas (LNG), from and to Canada over a two-year term beginning on the date of first delivery.

MASSPOWER intends to utilize existing pipeline and LNG facilities for the transportation of the volumes to be imported and exported and submit quarterly reports detailing each transaction.

The application is filed under section 3 of the Natural Gas Act (NGA) and DOE Delegation Order Nos. 0204-111 and 0204-127. Protests, motions to intervene, notices of intervention, and written comments are invited.

DATES: Protests, motions to intervene or notices of intervention, as applicable, requests for additional procedures and written comments are to be filed at the address listed below no later than 4:30 p.m., eastern time, December 26, 1991.

ADDRESSES: Office of Fuels Programs, Fossil Energy, U.S. Department of Energy, Forrestal Building, room 3F-056, FE-50, 1000 Independence Avenue, SW., Washington, DC 20585.

FOR FURTHER INFORMATION:

Allyson C. Reilly, Office of Fuels Programs, Fossil Energy, U.S. Department of Energy, Forrestal Building, room 3F-094, FE-53, 1000 Independence Avenue, SW., Washington, DC 20585, (202) 586-9394.
Diane Stubbs, Office of Assistant General Counsel for Fossil Energy, U.S. Department of Energy, Forrestal Building, room 6E-042, GC-14, 1000 Independence Avenue, SW., Washington, DC 20585, (202) 586-6667.

SUPPLEMENTARY INFORMATION:

MASSPOWER is a Massachusetts general partnership with its principal place of business in Boston, Massachusetts. MASSPOWER proposes to construct, own and operate a 239 megawatt, natural gas-fired, electric cogeneration facility in Springfield, Massachusetts.

MASSPOWER states that the requested blanket import authority will be for supplemental supplies for its facility if needed in the event of a temporary increase in fuel requirements or a temporary interruption in either of its primary fuel supplies. The export authority requested by MASSPOWER would give it the flexibility to market any excess gas available primarily due to climatic conditions or maintenance activities.

The decision on the application for import authority will be made consistent with DOE's gas import policy guidelines, under which the competitiveness of an import arrangement in the markets served is the primary consideration in determining whether it is in the public interest (49 FR 6684, February 22, 1984). In reviewing natural gas export applications, DOE considers the domestic need for the gas to be exported and any other issues determined to be appropriate in a particular case. Parties, especially those that may oppose this application, should comment in their responses on these considerations as set forth in the policy guidelines. The

applicant asserts that any imports made under this arrangement will be competitive and proposed exports are unlikely to be needed during the requested term of the authorization. Parties opposing the arrangement bear the burden of overcoming this assertion.

NEPA Compliance

The National Environmental Policy Act (NEPA), 42 U.S.C. 4321 *et seq.*, requires DOE to give appropriate consideration to the environmental effects of its proposed actions. No final decision will be issued in this proceeding until DOE has met its NEPA responsibilities.

Public Comment Procedures

In response to this notice, any person may file a protest, motion to intervene or notice of intervention, as applicable, and written comments. Any person wishing to become a party to the proceeding and to have their written comments considered as the basis for any decision on the application must, however, file a motion to intervene or notice of intervention, as applicable. The filing of a protest with respect to this application will not serve to make the protestant a party to the proceeding, although protests and comments received from persons who are not parties will be considered in determining the appropriate action to be taken on the application. All protests, motions to intervene, notices of intervention, and written comments must meet the requirements that are specified by the regulations in 10 CFR part 590. Protests, motions to intervene, notices of intervention, requests for additional procedures, and written comments should be filed with the Office of Fuels Programs at the above address.

It is intended that a decisional record will be developed on the application through responses to this notice by parties, including the parties' written comments and replies thereto. Additional procedures will be used as necessary to achieve a complete understanding of the facts and issues. A party seeking intervention may request that additional procedures be provided, such as additional written comments, an oral presentation, a conference, or trial-type hearing. Any request to file additional written comments should explain why they are necessary. Any request for an oral presentation should identify the substantial question of fact, law, or policy at issue, show that it is material and relevant to a decision in the proceeding, and demonstrate why an oral presentation is needed. Any request

for a conference should demonstrate why the conference would materially advance the proceeding. Any request for a trial-type hearing must show that there are factual issues genuinely in dispute that are relevant and material to a decision and that a trial-type hearing is necessary for a full and true disclosure of the facts.

If an additional procedure is scheduled, notice will be provided to all parties. If no party requests additional procedures, a final opinion and order may be issued based on the official record, including the application and responses filed by parties pursuant to this notice, in accordance with 10 CFR 590.316.

A copy of MASSPOWER's application is available for inspection and copying in the Office of Fuels Programs Docket Room, 3F-056, at the above address. The docket room is open between the hours of 8 a.m. and 4:30 p.m., Monday through Friday, except Federal holidays.

Issued in Washington, DC, November 19, 1991.

Clifford P. Tomaszewski,
Acting Deputy Assistant Secretary for Fuels
Programs, Office of Fossil Energy.

[FR Doc. 91-28272 Filed 11-22-91; 8:45 am]
BILLING CODE 6450-01-M

[FE Docket No. 91-81-NG]

Salmon Resources LTD.; Application for Blanket Authorization to Import Natural Gas From Canada

AGENCY: Department of Energy, Office of Fossil Energy.

ACTION: Notice of application for blanket authorization to import natural gas.

SUMMARY: The Office of Fossil Energy (FE) of the Department of Energy (DOE) gives notice of receipt on October 7, 1991, of an application filed by Salmon Resources Ltd. (Salmon) requesting that blanket authorization to import up to 100 Bcf of Canadian natural gas over a two-year period beginning on the date of first delivery after February 14, 1992, the date Salmon's current blanket import authority expires.

The application is filed under section 3 of the Natural Gas Act and DOE Delegation Order Nos. 0204-111 and 0204-127. Protests, motions to intervene, notices of intervention, and written comments are invited.

DATES: Protests, motions to intervene or notices of intervention, as applicable, requests for additional procedures and written comments are to be filed at the address listed below no later than 4:30 p.m., eastern time, December 26, 1991.

ADDRESSES: Office of Fuels Programs, Fossil Energy, U.S. Department of Energy, Forrestal Building, room 3F-056, FE-50, 1000 Independence Avenue, SW., Washington, DC 20585.

FOR FURTHER INFORMATION:

Frank Duchaine, Fuels Programs, Office of Fossil Energy, U.S. Department of Energy, Forrestal Building, room 3H-087, FE-53, 1000 Independence Avenue, SW., Washington, DC 20585, (202) 586-8233.

Diane Stubbs, Office of Assistant General Counsel for Fossil Energy, U.S. Department of Energy, Forrestal Building, room 6E-042, GC-14, 1000 Independence Avenue, SW., Washington, DC 20585, (202) 586-6667.

SUPPLEMENTARY INFORMATION: Salmon, a Wyoming corporation with its principal place of business in Lakewood, Colorado, is a wholly owned subsidiary of Shell Canada Limited, a Canadian corporation headquartered in Calgary, Alberta. The blanket authorization sought by Salmon would extend import authority granted originally by DOE/ERA Opinion and Order No. 94, issued December 16, 1985 (ERA Docket No. 85-18-NG), extended by DOE/ERA Opinion and Order No. 217, issued January 22, 1988 (ERA Docket No. 87-50-NG), and extended again by DOE/ERA Opinion and Order No. 370, issued January 11, 1990 (ERA Docket No. 89-71-NG).

Salmon intends to import gas, either for its own account or on behalf of others, from Shell or other Canadian suppliers. Each sale, Salmon asserts, would be market responsive and the gas would be sold to a range of U.S. purchasers, including industrial end users, agricultural users, electric utilities, pipelines, and local distribution companies. Imports would be accomplished using existing pipeline capacity and Salmon indicated it would file reports with FE within 30 days after the end of each calendar quarter giving the details of the individual transactions.

The decision on the application for import authority will be made consistent with the DOE's gas import policy guidelines, under which the competitiveness of an import arrangement in the markets served is the primary consideration in determining whether it is in the public interest (49 FR 6684, February 22, 1984). Parties that may oppose this application should comment in their responses on the issue of competitiveness as set forth in the policy guidelines. The applicant asserts that this import arrangement will be competitive and thus in the public interest. Parties opposing the

arrangement bear the burden of overcoming this assertion.

NEPA Compliance

The National Environmental Policy Act (NEPA), 42 U.S.C. 4321, *et seq.*, requires DOE to give appropriate consideration to the environmental effects of its proposed actions. No final decision will be issued in this proceeding until DOE has met its NEPA responsibilities.

Public Comment Procedures

In response to this notice, any person may file a protest, motion to intervene or notice of intervention, as applicable, and written comments. Any person wishing to become a party to the proceeding and to have their written comments considered as the basis for any decision on the application must, however, file a motion to intervene or notice of intervention, as applicable. The filing of a protest with respect to this application will not serve to make the protestant a party to the proceeding, although protests and comments received from persons who are not parties will be considered in determining the appropriate action to be taken on the application. All protests, motions to intervene, notices of intervention, and written comments must meet the requirements that are specified by the regulations in 10 CFR part 590. Protests, motions to intervene, notices of intervention, requests for additional procedures, and written comments should be filed with the Office of Fuels Programs at the above address.

It is intended that a decisional record will be developed on the application through responses to this notice by parties, including the parties' written comments and replies thereto. Additional procedures will be used as necessary to achieve a complete understanding of the facts and issues. A party seeking intervention may request that additional procedures be provided, such as additional written comments, an oral presentation, a conference, or trial-type hearing. Any request to file additional written comments should explain why they are necessary. Any request for an oral presentation should identify the substantial question of fact, law, or policy at issue, show that it is material and relevant to a decision in the proceeding, and demonstrate why an oral presentation is needed. Any request for a conference should demonstrate why the conference would materially advance the proceeding. Any request for a trial-type hearing must show that there are factual issues genuinely in dispute

that are relevant and material to a decision and that a trial-type hearing is necessary for a full and true disclosure of the facts. If an additional procedure is scheduled, notice will be provided to all parties. If no party requests additional procedures, a final opinion and order may be issued based on the official record, including the application and responses filed by parties pursuant to this notice, in accordance with 10 CFR 590.316.

A copy of Salmon's application is available for inspection and copying in the Office of Fuels Programs Docket Room 3F-056 at the above address. The docket room is open between the hours of 8 a.m. and 4:30 p.m., Monday through Friday, except Federal holidays.

Issued in Washington, DC, November 18, 1991.

Clifford P. Tomaszewski,

Acting Deputy Assistant Secretary for Fuels Programs, Office of Fossil Energy.

[FR Doc. 91-28273 Filed 11-22-91; 8:45 am]

BILLING CODE 6450-01-M

[FE Docket No. 91-68-NG]

Tenaska Gas Co.; Application to Import Natural Gas From Canada

AGENCY: Department of Energy, Office of Fossil Energy.

ACTION: Notice of application for blanket authorization to import natural gas from Canada.

SUMMARY: The Office of Fossil Energy of the Department of Energy (DOE) gives notice of receipt on August 23, 1991, of an application filed by Tenaska Gas Co. (Tenaska), requesting blanket authorization to import up to 60,000 Mcf per day of natural gas from Canada and up to an aggregate total of 43.8 Bcf over a two-year period commencing with the date of first delivery. Tenaska intends to use existing pipeline facilities within the United States and states that it will submit quarterly reports detailing each transaction.

The application is filed under section 3 of the Natural Gas Act and DOE Delegation Order Nos. 0204-111 and 0204-127. Protests, motions to intervene, notices of intervention and written comments are invited.

DATES: Protests, motions to intervene or notices of intervention, as applicable, requests for additional procedures and written comments are to be filed at the address listed below no later than 4:30 p.m., Eastern time December 26, 1991.

ADDRESSES: Office of Fuels Programs, Fossil Energy, U.S. Department of Energy, Forrestal Building, room 3F-056,

FE-50, 1000 Independence Avenue, SW., Washington, DC 20585, (202) 586-9478.

FOR FURTHER INFORMATION CONTACT:

Stanley C. Vass, Office of Fuels Programs, Fossil Energy, U.S. Department of Energy, Forrestal Building, room 3F-094, FE-53, 1000 Independence Avenue, SW., Washington, DC 20585, (202) 586-9482.

Diane Stubbs, Office of Assistant General Counsel for Fossil Energy, Office of General Counsel U.S. Department of Energy, Forrestal Building, room 6E-042, GC-14, 1000 Independence Avenue, SW., Washington, D.C. 20585, (202) 586-6667.

SUPPLEMENTARY INFORMATION:

Tenaska is a corporation organized under the laws of the State of Nebraska with its principal place of business in Omaha, Nebraska. Tenaska proposes to purchase gas from Canadian producers and others at market responsive prices for sale to various United States customers, which might include distribution companies, pipeline companies, other marketers of natural gas and end users.

The decision on Tenaska's application for import authority will be made consistent with DOE's natural gas import policy guidelines, under which the competitiveness of an import arrangement in the markets served is the primary consideration in determining whether it is in the public interest (49 FR 6684, February 22, 1984). Parties, especially those that may oppose this application, should comment on the issue of competitiveness as set forth in the policy guidelines regarding the requested import authority. The applicant asserts that imports made under the proposed arrangement will be competitive. Parties opposing the arrangement bear the burden of overcoming this assertion.

All persons should be aware that if DOE approves this import, it may designate just a total term volume in order to provide Tenaska with maximum operating flexibility.

NEPA Compliance

The National Environmental Policy Act (NEPA), 42 U.S.C., 4321 *et seq.*, requires DOE to give appropriate consideration to the environmental effects of its proposed actions. No final decision will be issued in this proceeding until DOE has met its NEPA responsibilities.

Public Comment Procedures

In response to this notice, any person may file a protest, motion to intervene or notice of intervention, as applicable,

and written comments. Any person wishing to become a party to the proceeding and to have their written comments considered as the basis for any decision on the application must, however, file a motion to intervene or notice of intervention, as applicable. The filing of a protest with respect to this application will not serve to make the protestant a party to the proceeding, although protests and comments received from persons who are not parties will be considered in determining the appropriate action to be taken on the application. All protests, motions to intervene, notices of intervention, and written comments must meet the requirements that are specified by the regulations in 10 CFR part 590. Protests, motions to intervene, notices of intervention, requests for additional procedures, and written comments should be filed with the Office of Fuels Programs at the above address.

It is intended that a decisional record will be developed on the application through responses to this notice by parties, including the parties' written comments and replies thereto. Additional procedures will be used as necessary to achieve a complete understanding of the facts and issues. A party seeking intervention may request that additional procedures be provided, such as additional written comments, an oral presentation, a conference, or trial-type hearing. Any request to file additional written comments should explain why they are necessary. Any request for an oral presentation should identify the substantial question of fact, law, or policy at issue, show that it is material and relevant to a decision in the proceeding, and demonstrate why an oral presentation is needed. Any request for a conference should demonstrate why the conference would materially advance the proceeding. Any request for a trial-type hearing must show that there are factual issues genuinely in dispute that are relevant and material to a decision and that a trial-type hearing is necessary for a full and true disclosure of the facts.

If an additional procedure is scheduled, notice will be provided to all parties. If no party requests additional procedures, a final opinion and order may be issued based on the official record, including the application and responses filed by parties pursuant to this notice, in accordance with 10 CFR 590.316.

A copy of Tenaska's application is available for inspection and copying in the Office of Fuels Programs Docket Room, 3F-056, at the above address. The

docket room is open between the hours of 8 a.m. and 4:30 p.m., Monday through Friday, except Federal holidays.

Issued in Washington, DC, November 18, 1991.

Clifford P. Tomaszewski,

Acting Deputy Assistant Secretary for Fuels Programs, Office of Fossil Energy.

[FR Doc. 91-28274 Filed 11-22-91; 8:45 am]

BILLING CODE 6540-01-M

[FE Docket No. 91-60-NG]

TranAm Energy Inc.; Order Granting Blanket Authorization to Import and Export Natural Gas

AGENCY: Department of Energy, Office of Fossil Energy.

ACTION: Notice of an order granting blanket authorization to import and export natural gas.

SUMMARY: The Office of Fossil Energy of the Department of Energy gives notice that it has issued an order granting TranAm Energy Inc. blanket authorization to import and export up to 100 Bcf of natural gas from and to Canada and Mexico, over a two-year period beginning on the date of first delivery.

A copy of this order is available for inspection and copying in the Office of Fuels Programs Docket Room, 3F-056, Forrestal Building, U.S. Department of Energy, 1000 Independence Avenue, SW., Washington, DC 20585, (202) 586-9478. The docket room is open between the hours of 8 a.m. and 4:30 p.m., Monday through Friday, except Federal holidays.

Issued in Washington, DC, November 18, 1991.

Clifford P. Tomaszewski,

Acting Deputy Assistant Secretary for Fuels Programs, Office of Fossil Energy.

[FR Doc. 91-28275 Filed 11-22-91; 8:45 am]

BILLING CODE 6450-01-M

ENVIRONMENTAL PROTECTION AGENCY

[FRL-4034-2]

Agency Information Collection Activities Under OMB Review

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*), this notice announces that the Information Collection Request (ICR) abstracted below has been forwarded to the Office of Management and Budget

(OMB) for review and comment. The ICR describes the nature of the information collection and its expected cost and burden.

DATES: Comments must be submitted on or before December 26, 1991.

FOR FURTHER INFORMATION CONTACT: Sandy Farmer at EPA, (202) 260-2740.

SUPPLEMENTARY INFORMATION:

Office of Solid Waste and Emergency Response

Title: Facility Ground-Water Monitoring Requirements (EPA No. 0959.07). This ICR is a reinstatement of a previously approved information collection (OMB No. 2050-0033).

Abstract: Pursuant to Subtitle C of the Resource Conservation and Recovery Act (RCRA) of 1976, 40 CFR part 264 and 40 CFR part 265 establish ground-water monitoring regulations for permitted and interim status facilities, respectively. These regulations establish programs for protecting ground-water from releases of hazardous wastes by land disposal facilities (LDFs). Ultimately, the EPA will use the information provided by LDFs to make decisions regarding the type and status of monitoring programs, and what corrective actions, if any, must be taken by the LDFs to protect ground-water.

Owners or operators of permitted LDFs must perform detection monitoring. In addition to monitoring, activities associated with detection monitoring include: (1) Notifying EPA of statistically significant concentrations of hazardous leachate when detected; and (2) gathering and maintaining records on all data pertaining to ground-water collected during monitoring. If it has been determined by EPA that the concentrations of hazardous waste leachate pose sufficient risk to ground-water, then the LDF must conduct compliance monitoring of ground-water in addition to detection monitoring.

The information collection activities associated with compliance monitoring include: (1) Gathering and maintaining records on all ground-water data and analyses collected during monitoring; (2) notifying EPA of ground-water contamination, the presence of new constituents in the ground water, and instances where unacceptable concentrations of contaminants have been found. In the event that a leak is detected at an unacceptable concentration, the LDF must provide EPA with engineering feasibility plans and reports on corrective action, or provide EPA with all data necessary to establish an alternate concentration limit (ACL).

Owners or operators of interim status LDFs, must establish water-quality assessment programs. The information collection activities associated with the program include: (1) Preparing a sampling and analysis plan for monitoring ground-water contamination; (2) notifying EPA of changes to indicator parameter concentrations; (3) submitting a ground-water quality assessment report; (4) gathering and maintaining records on analyses and evaluations conducted under the program; and (5) submitting annual quality assessment reports to the Regional Administrator.

Owners or operators of interim status LDFs seeking exemption or the use of alternative systems of ground water monitoring, must first demonstrate to EPA, in writing, that they pose little or not risk of contaminating ground-water. If low risk is demonstrated, owners or operators of these facilities must continue to: (1) Gather and maintain records of ground-water data; (2) report on the parameters of drinking water suitability during the first year; (3) report annually on parameters indicative of water quality, sample variances from background concentrations, and ground-water surface information pertaining to groundwater analysis.

Burden Statement: Public reporting burden for this collection of information is estimated to average 119 hours per response including time for reviewing instructions, searching existing information sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Public recordkeeping burden for this collection of information is estimated to average 178 hours per respondent, annually.

Respondents: Businesses or other for-profit organizations; Federal agencies; small businesses or organizations; State and local governments.

Estimated number of respondents: 958.

Frequency of collection: Annually, or when ground-water contamination is detected.

Estimated number of responses per respondent: 1.

Estimated total annual burden: 150,207 hours.

Send comments regarding the burden estimate, or any other aspect of this collection of information, including suggestions for reducing the burden, to:

Sandy Farmer, U.S. Environmental Protection Agency, Information Policy Branch (PM-223Y), 401 M Street, SW., Washington, DC 20460; and Jonathan Gledhill, Office of Management and Budget, Office of

Information and Regulatory Affairs,
725 17th St., NW., Washington, DC
20503.

Dated: November 14, 1991.

Paul Lapsley,

Director, Regulatory Management Division.

[FR Doc. 91-28248 Filed 11-22-91; 8:45 am]

BILLING CODE 6560-50-M

[FRL-4034-3]

Agency Information Collection Activities Under OMB Review

AGENCY: Environmental Protection
Agency (EPA).

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*), this notice announces that the Information Collection Request (ICR) abstracted below has been forwarded to the Office of Management and Budget (OMB) for review and comment. The ICR describes the nature of the information collection and its expected cost and burden. This notice also announces our request for an expedited review under 5 CFR 1320.18.

DATES: Comments must be submitted on or before December 26, 1991.

FOR FURTHER INFORMATION CONTACT: Sandy Farmer at EPA, (202) 260-2740.

SUPPLEMENTARY INFORMATION:

Office of Solid Waste and Emergency Response

Title: RCRA Financial Responsibility Requirements for Underground Storage Tanks (ICR No. 1359.03). This ICR is a reinstatement of a previously approved collection (OMB No. 2050-0066).

Abstract: This ICR details the information collection activities associated with the financial responsibility requirements for owners and operators of underground storage tanks (UST) as provided in subpart I, Financial Responsibility Requirements, 40 CFR part 280. Owners or operators of underground storage tanks (USTs) containing petroleum must obtain evidence of financial responsibility for UST releases. In order to comply with the requirements, owners or operators of USTs containing petroleum must obtain one of the financial instruments specified in the regulation, which include: guarantees, trust funds, insurance, risk retention group coverage, surety bonds, letters of credit, state-required mechanisms, and state funds or other state assurances.

On occasion, owners or operators who obtain a financial instrument must report to EPA on the status of financial assurance instruments, their financial

status or the financial status of institutions issuing the instruments. In addition, owners or operators must maintain records of the financial instrument along with a statement that they are in compliance with the financial responsibility requirements.

Burden Statement: The average public reporting burden for this collection is estimated to be 2 hours per response. This estimate includes all aspects of the information collection including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. The estimated annual burden per recordkeeper is 0.08 hours.

Respondents: Underground Storage Tank Owners and Operators.

Estimated Number of Respondents: 288,642.

Estimated Number of Responses per Respondent: 1.

Estimated Total Annual Burden on Respondents: 67,513 hours.

Frequency of Collection: On occasion.

Expedited Review: A request for an expedited review of this ICR is made under the Paperwork Reduction Act (5 CFR, 1320.18), as a lapse in approval for an extended period of time will significantly hamper EPA's financial responsibility enforcement efforts and could ultimately result in harm to human health and the environment.

Send comments regarding the burden estimate, or any other aspect of this collection of information, including suggestions for reducing the burden, to: Sandy Farmer, U.S. Environmental Protection Agency, Information Policy Branch (PM-223Y), 401 M Street, SW., Washington, DC 20460; and Jonathan Gledhill, Office of Management and Budget, Office of Information and Regulatory Affairs, 725 17th St., NW., Washington, DC 20503.

Dated: November 18, 1991.

Paul Lapsley,

Director, Regulatory Management Division.

[FR Doc. 91-28249 Filed 11-25-91; 8:45 am]

BILLING CODE 6560-50-M

[FRL-4034-6; ECAO-CD-86-082]

Draft Criteria Document for Oxides of Nitrogen

AGENCY: Environmental Protection Agency.

ACTION: Notice of availability of external review draft.

SUMMARY: This notice announces the availability of an external review draft of a revised air quality criteria document of oxides of nitrogen. This draft was prepared by the Environmental Criteria and Assessment Office (ECAO) of EPA's Office of Health and Environmental Assessment, a part of the Office of Research and Development.

DATES: The Agency will make the external review draft available for public review and comment on or about November 25, 1991. Comments must be in writing and postmarked by February 28, 1992.

ADDRESSES: To obtain a copy of the external review draft document, interested parties should contract the ORD Publications Center, CERL-FRN, U.S. Environmental Protection Agency, 26 West Martin Luther King Drive, Cincinnati, OH 45268, (513) 569-7562 or FTS 684-7562, and request the external review draft of the revised Air Quality Criteria for Oxides of Nitrogen. Please provide your name, mailing address, and the EPA document number, EPA/600/8-91/049A.

The draft document will also be available for public inspection and copying at the EPA Library, EPA Headquarters, Waterside Mall, 401 M Street SW., Washington, DC.

Comments on the draft should be sent to the Project Manager for Oxides of Nitrogen, U.S. Environmental Protection Agency MD-52, Research Triangle Park, NC 27711.

FOR FURTHER INFORMATION CONTACT: Ms. Dinae Ray, U.S. Environmental Protection Agency, Environmental Criteria and Assessment Office, MD-52, Research Triangle Park, NC 27711 (919) 541-3637 or FTS 629-3637.

SUPPLEMENTARY INFORMATION: Section 109 (d)(1) of the Clean Air Act, 42 U.S.C. 57409(d)(1), requires periodic review and, as appropriate, revision of air quality criteria documents in connection with review and possible revision of existing national ambient air quality standards. EPA is revising the existing air quality criteria document for oxides of nitrogen as announced in the *Federal Register* on July 22, 1987 (52 FR 27580). To help assure the accuracy and completeness of the revised document, and external review draft is being released for public review and comment.

Dated: November 19, 1991.

Erich W. Bretthauer,

Assistant Administrator for Research and Development.

[FR Doc. 91-28255 Filed 11-22-91; 8:45 am]

BILLING CODE 6560-50-M

(FRL-4034-41)

**Ordnance Research, Inc. Site;
Proposed Settlement****AGENCY:** Environmental Protection Agency.**ACTION:** Notice of proposed settlement.

SUMMARY: Under section 122(h) of the Comprehensive Environmental Response, Compensation and Liability Act (CERCLA), the Environmental Protection Agency (EPA) has agreed to settle claims for response costs at the Ordnance Research, Inc. Site, Fort Walton Beach, Florida, with Ordnance Research, Inc. and Mr. Fred W. Shintz. EPA will consider public comments on the proposed settlement for thirty days. EPA may withdraw from or modify the proposed settlement should such comments disclose facts or considerations which indicate the proposed settlement is inappropriate, improper, or inadequate. Copies of the proposed settlement are available from: Ms. Carolyn McCall, Waste Programs Branch, Waste Management Division, U.S. EPA, Region IV, 345 Courtland Street, NE., Atlanta, Georgia 30365, (404) 347-5059.

Written comment may be submitted to the person above within 30 days of the date of publication.

Dated: November 6, 1991.

Elmer W. Aiken,

Acting Director, Waste Management Division.

[FR Doc. 91-28250 Filed 11-22-91; 8:45 am]

BILLING CODE 6560-50-M

**FEDERAL COMMUNICATIONS
COMMISSION****Public Information Collection
Requirement Submitted to Office of
Management and Budget for Review**

November 14, 1991.

The Federal Communications Commission has submitted the following information collection requirement to OMB for review and clearance under the Paperwork Reduction Act of 1980 (44 U.S.C. 3507).

Copies of this submission may be purchased from the Commission's copy contractor, Downtown Copy Center, 1114 21st Street, NW., Washington, DC 20036, (202) 452-1422. For further information on this submission contact Judy Boley, Federal Communications Commission, (202) 632-7513. Persons wishing to comment on this information

collection should contact Jonas Neihardt, Office of Management and Budget, room 3235 NEOB, Washington, DC 20503, (202) 395-4814.

OMB number: None.

Title: Document Index Terms.

Action: New collection.

Respondents: Businesses or other for-profit (including small businesses).

Frequency of response: On occasion reporting.

Estimated annual burden: 21,120 responses; .017 hours average burden per recordkeeper; 360 hours total annual burden.

Needs and uses: The Federal Communications Commission is planning to implement a Records Imaging Processing System (RIPS) for storage and retrieval of docketed, rulemaking and Petition for Rulemaking proceedings. The system will provide the public and staff with same day access to these documents filed at the FCC. Access to specified documents is obtained through the use of the "index terms" which point the way to individual documents. In order to provide same-day retrieval to the public and FCC staff, we are requesting that filers of these documents voluntarily attach a list of index terms to the first page of their filing. The provision of this information is technically required in order to index documents as they are optically scanned into the RIPS system. Without such indexing by filers, access to documents would either be delayed, or at best, the system would be prohibitively expensive to implement. Federal Communications Commission.

Donna R. Searcy,

Secretary.

[FR Doc. 91-28261 Filed 11-22-91; 8:45 am]

BILLING CODE 6712-01-M

**Public Information Collection
Requirement Submitted to Office of
Management and Budget for Review**

November 19, 1991.

The Federal Communications Commission has submitted the following information collection requirement to OMB for review and clearance under the Paperwork Reduction Act of 1980 (44 U.S.C. 3507).

Copies of this submission may be purchased from the Commission's copy contractor, Downtown Copy Center, 1114 21st Street, NW., Washington, DC 20036, (202) 452-1422. For further information on this submission contact Judy Boley, Federal Communications Commission, (202) 632-7513. Persons wishing to comment on this information

collection should contact Jonas Neihardt, Office of Management and Budget, room 3235 NEOB, Washington, DC 20503, (202) 395-4814.

OMB number: 3060-0464.

Title: Amendment of Parts 21, 43, 74, 78 and 94 of the Commission's Rules Governing Use of the Frequencies in the 2.1 and 2.5 GHz Bands Affecting: Private Operational-Fixed Microwave Service, Multipoint Distribution Service (MDS), Multichannel Multipoint Distribution Service (MMDS), Instructional Television Fixed Service (ITFS) and Cable Television Relay Service (CARS)—Gen. Docket Nos. 90-54 and 80-113.

Action: Revision.

Respondents: Businesses or other for-profit (including small businesses).

Frequency of response: On occasion reporting and annually.

Estimated annual burden: 627 responses; 10.40 hours average burden per response; 6,520 hours total annual burden.

Needs and uses: A Report and Order was adopted to facilitate the development of wireless cable service as a viable competitor in the multichannel video marketplace, by revising the rules governing the various microwave radio channels that can be used collectively to provide wireless cable service. The Order of Reconsideration modifies and clarifies some decisions made in the Report and Order. Rule changes included new standards for: (1) Interference protection for ITFS stations which lease excess capacity to wireless cable operators; (2) ITFS excess capacity leasing requirements; (3) signal boosters of very low power; (4) interference analyses filed by MMDS applicants with regard to ITFS stations; (5) ITFS service requirements for MMDS applicants; and (6) CARS eligibility. The data will be used by FCC staff to determine whether the applicant is qualified legally, technically and financially to be licensed to use microwave radio frequencies. Without such information the FCC could not determine whether to issue construction authorizations and licenses to the applicants that provide telecommunications services to the public.

Federal Communications Commission.

Donna R. Searcy,

Secretary.

[FR Doc. 91-28282 Filed 11-22-91; 8:45 am]

BILLING CODE 6712-01-M

FEDERAL MARITIME COMMISSION**Agreement(s) Filed; Empresa De Navegacao Internacional (Navinter), et al.**

The Federal Maritime Commission hereby gives notice of the filing of the following agreement(s) pursuant to section 5 of the Shipping Act of 1984.

Interested parties may inspect and obtain a copy of each agreement at the Washington DC Office of the Federal Maritime Commission, 1100 L Street, NW., room 10325. Interested parties may submit comments on each agreement to the Secretary, Federal Maritime Commission, Washington, DC 20573, within 10 days after the date of the **Federal Register** in which this notice appears. The requirements for comments are found in § 572.603 of title 46 of the Code of Federal Regulations. Interested persons should consult this section before communicating with the Commission regarding a pending agreement.

Agreement No.: 202-011259-002.

Title: United States/Southern Africa Conference Agreement.

Parties: Empresa De Navegacao Internacional (Navinter), Lykes Bros. Steamship Co., Inc., Safbank Line, Ltd. (safbank).

Synopsis: The proposed modification revises article 7 to provide for a \$35,000 membership admission fee.

Agreement No.: 232-011358.

Title: VSA/Italia Space Charter and Sailing Agreement.

Parties: Italia di Navigazione, S.p.A. ("Italia"), FMC Agreement No. 203-011171 ("011171").

Synopsis: The proposed Agreement would permit the parties to charter space to one another, to discuss and agree upon the interchange and leasing of containers and to rationalize sailings in the trade between United States East Coast ports in the Portland, Maine/Savannah, Georgia range and ports in Italy, France and Spain and inland points via such origin/destination ports.

Agreement No.: 224-200592.

Title: Maryland Port Administration/Maersk Line Marine Terminal Agreement.

Parties: Maryland Port Administration ("MPA"), Maersk, Inc. ("MAERSK").

Synopsis: The Agreement, filed November 14, 1991, provides for MPA and MAERSK to enter into a lease agreement. MAERSK will lease from MPA thirty-six acres at the Dundalk Marine Terminal. The term of the Agreement is for ten years.

Agreement No.: 224-200593.

Title: Agreement & Lease Between The Maryland Port Administration and

Universal Maritime Services Corporation.

Parties: Maryland Port Administration (MPA), Universal Maritime Services Corporation ("Universal").

Synopsis: The Agreement and lease provides Universal the use of portions of the Dundalk Marine Terminal for a term of ten years.

Dated: November 19, 1991.

By Order of the Federal Maritime Commission.

Joseph C. Polking,
Secretary.

[FR Doc. 91-28205 Filed 11-22-91; 8:45 am]

BILLING CODE 6370-01-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Centers for Disease Control****National Center for Prevention Services, HIV Counseling; Meeting**

The National Center for Prevention Services (NCPS) of the Centers for Disease Control (CDC) announces the following meeting.

Name: HIV Counseling Meeting

Time and Date: 8:30 a.m.-4:30 p.m.,
December 10, 1991.

Place: Terrace Garden Inn-Buckhead, Terrace Ballroom West, 3405 Lenox Road, NE., Atlanta, Georgia 30326, telephone 404/261-9250.

Status: Open to the public, limited only by space available.

Purpose: To obtain individual input from CDC and NCPS program staff, state HIV/sexually transmitted diseases (STD) project directors, HIV counselors, HIV/STD clinic managers, program staff from community-based organizations, social scientists, and representatives from various national HIV organizations regarding program issues related to the public health functions of HIV counseling. From these discussions, CDC may produce additional technical guidance for counselors and program managers and may, in addition, refine its own technical assistance and training activities related to counseling.

Matters To Be Discussed: The meeting will focus on a number of important public health questions, such as:

- What counseling techniques can be employed to facilitate self-assessment and awareness of HIV risk?
- How can counseling messages be structured to ensure that important prevention messages are understood and accepted by clients?
- What counseling techniques can be employed to maximize return for post-test counseling?
- What lessons have we learned about the relationship between HIV counseling and behavior change?

Contact Person for More Information: Sandra H. Kerr, Public Health Analyst, NCPS (HIV), CDC, MS E07, 1600 Clifton Road, NE.,

Atlanta, Georgia 30333, telephone 404/633-1480 or FTS 236-1480.

Dated: November 19, 1991.

Elvin Hilyer,
Associate Director for Policy Coordination,
Centers for Disease Control.

[FR Doc. 91-28215 Filed 11-22-91; 8:45 am]

BILLING CODE 4160-18-M

Board of Scientific Counselors, National Institute for Occupational Safety and Health: Meeting

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92-463), the Centers for Disease Control (CDC) announces the following meeting.

Name: Board of Scientific Counselors, National Institute for Occupational Safety and Health (NIOSH).

Time and Date: 8:30 a.m.-4:30 p.m.,
December 10, 1991.

Place: Terrace Garden Inn-Buckhead, 3405 Lenox Road, NE., Atlanta, Georgia 30326.

Status: Open to the public, limited only by the space available.

Purpose: The Board provides advice to the Director, NIOSH, on NIOSH research programs. Specifically, the Board provides guidance on the Institute's research activities related to developing and evaluating hypotheses, systematically documenting findings, and disseminating results.

Matters To Be Discussed: The agenda will include the NIOSH Director's report and presentations on scientific issues such as visiting scientists, plans for a new research facility, research grants programs, agricultural center grants, and surveillance activities. Agenda items are subject to change as priorities dictate.

Contact Person for More Information: Betty H. Dryden, Committee Management Specialist, Office of the Deputy Director, NIOSH, 1600 Clifton Road, NE., Mailstop D-26, Atlanta, Georgia 30333, telephone (404) 639-1530 or FTS 236-1530.

Dated: November 20, 1991.

Elvin Hilyer,
Associate Director for Policy Coordination,
Centers for Disease Control.

[FR Doc. 91-28339 Filed 11-22-91; 8:45 am]

BILLING CODE 4160-19-M

The National Institute for Occupational Safety and Health (NIOSH) of the Centers for Disease Control (CDC) Announces the Following Meeting

Name: Consultant Meeting on Ultraviolet Germicidal Irradiation.

Times and Dates: 8 a.m.-5:30 p.m.,
December 10, 1991. 8:30 a.m.-12 noon,
December 11, 1991.

Place: Travelodge Hotel-Atlanta, North Druid Hills Road at I-85, NE., Atlanta, Georgia 30329.

Status: Open to the public, limited only by the space available.

Purpose: Consultants will examine issues regarding the use of ultraviolet germicidal irradiation in health care settings for controlling transmission of tuberculosis.

Contact Person for Additional Information: Lillian Glickman, PACE Enterprises, Inc., 17 Executive Park Drive, NE., suite 200, Atlanta, Georgia 30329, telephone 404/633-8610.

Dated: November 19, 1991.

Elvin Hilyer,

Associate Director for Policy Coordination,
Centers for Disease Control.

[FR Doc. 91-28216 Filed 11-22-91; 8:45 am]

BILLING CODE 4160-19-M

National Committee on Vital and Health Statistics (NCVHS) Subcommittee on State and Community Health Statistics; Meeting

Pursuant to Public Law 92-463, the National Center for Health Statistics (NCHS), Centers for Disease Control, announces the following meeting.

Name: NCVHS Subcommittee on State and Community Health Statistics.

Times and Dates: 1 p.m.-5 p.m., December 11, 1991. 9 a.m.-5 p.m., December 12, 1991.

Place: Room 303A-305A, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

Status: Open.

Purpose: The purpose of this meeting is for the Subcommittee to continue to explore issues and concerns about the availability of statistics to monitor the health of communities.

Contact Person for More Information: Substantive program information as well as summaries of the meeting and a roster of committee members may be obtained from Gail F. Fisher, Ph.D., Executive Secretary, NCVHS, NCHS, room 1100, Presidential Building, 6525 Belcrest Road, Hyattsville, Maryland 20782, telephone 301/436-7050 or FTS 436-7050.

Dated: November 19, 1991.

Elvin Hilyer,

Associate Director for Policy Coordination,
Centers for Disease Control.

[FR Doc. 91-28217 Filed 11-22-91; 8:45 am]

BILLING CODE 4160-18-M

Food and Drug Administration

[Docket No. 79N-0001; DESI 7832]

Nylidrin Hydrochloride; Final Order on Objections and Request for a Hearing; Withdrawal of Approval of New Drug Application

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Commissioner of Food and Drugs denies a hearing and withdraws approval of the new drug application (NDA) held by Rorer

Pharmaceutical Corp., for Arlidin Tablets. This product, which contains nylidrin hydrochloride, is labeled for treatment of peripheral vascular disease and certain disturbances of the inner ear. The basis of the withdrawal is that the drug lacks substantial evidence of effectiveness for its labeled indications.

EFFECTIVE DATE: December 26, 1991.

FOR FURTHER INFORMATION CONTACT: Margaret F. Sharkey, Center for Drug Evaluation and Research (HFD-366), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301-295-8041.

SUPPLEMENTARY INFORMATION: In a notice published in the Federal Register of July 20, 1971 (36 FR 13347), the Food and Drug Administration (FDA) announced its evaluation of reports received from the National Academy of Sciences/National Research Council, Drug Efficacy Study Group (NAS/NRC) concerning Arlidin Tablets (NDA 9-367; now held by Rorer Pharmaceuticals, a division of Rorer Pharmaceutical Corporation, 500 Virginia Drive, Fort Washington, PA 19034 (formerly held by USV Laboratories, Inc., P.O. Box 345, Manati, PR 00701; hereafter collectively referred to as USV/Rorer)). FDA evaluated Arlidin Tablets as lacking substantial evidence of effectiveness for cerebrovascular disorders such as arteriosclerosis, for other ischemic disturbances of the brain and eye, and for livedo reticularis. The agency also evaluated the drug product as possibly effective for treatment of peripheral vascular disease and certain circulatory disturbances of the inner ear. FDA allowed affected manufacturers 60 days to delete all indications classified as lacking substantial evidence of effectiveness and 6 months to provide substantial evidence for the possibly effective indications.

On September 3, 1971, USV/Rorer deleted from Arlidin's labeling those indications that had been classified as lacking substantial evidence of effectiveness. The firm also submitted protocols for the study of Arlidin for its possibly effective uses.

In a notice published in the Federal Register of December 14, 1972 (37 FR 26623), as amended on July 11, 1973 (38 FR 18477), FDA announced that several peripheral vasodilator drug products not proven to be effective, including Arlidin Tablets, were temporarily exempt from the schedule established by the court in *American Public Health Ass'n v. Veneman*, 349 F. Supp. 1311 (D.D.C. 1972), for completing the Drug Efficacy Study Implementation (DESI) program (Paragraph XIV exemption). This exemption was intended to allow

manufacturers additional time to design and conduct further studies to determine the effectiveness of their products for which FDA found there was a compelling medical need. These products were exempted because many variables characteristic of peripheral vascular disease required complex protocols and studies of long duration.

Under the exemption, USV/Rorer submitted numerous protocols for studies of Arlidin in the treatment of peripheral vascular disease, vertigo, and tinnitus. However, during the exemption period, the firm submitted the results of only two studies in support of its claim that Arlidin is effective in the treatment of peripheral vascular disease. Neither study was able to distinguish Arlidin from a placebo. Manufacturers of other exempted peripheral vasodilator drug products also failed to demonstrate the effectiveness of their products.¹

In a notice published in the Federal Register of May 25, 1979 (44 FR 30436), FDA announced that because more than 6 years had been allowed to study peripheral vasodilator drugs and their effectiveness had not been demonstrated, the agency had decided to revoke the paragraph XIV exemption for these products. In another notice, also appearing in the Federal Register of May 25, 1979 (44 FR 30443), the Director of the Bureau of Drugs (now the Center for Drug Evaluation and Research) reclassified nylidrin hydrochloride (Arlidin) to lacking substantial evidence of effectiveness, proposed to withdraw approval of the NDA for Arlidin, and offered an opportunity for a hearing on the proposal. In response, the following manufacturers requested a hearing:

- (1) USV/Rorer for Arlidin Tablets;
- (2) Cord Laboratories, Inc. (Cord), 2555 W. Midway Blvd., Broomfield, CO 80020, for a generic version of nylidrin hydrochloride;

¹ FDA has withdrawn or proposed to withdraw approval of all the other peripheral vasodilators labeled for use in peripheral vascular disease, circulating disturbances of the inner ear, or cerebral vascular conditions. FDA has withdrawn approval of tolazoline hydrochloride, azapetine phosphate, nicotinic alcohol, and dioxylone phosphate as lacking substantial evidence of effectiveness. FDA has also required modification of the labeling of phenoxybenzamine hydrochloride to delete all claims relating to peripheral vascular disease.

For two drugs, isoxsuprine hydrochloride (September 28, 1984, 49 FR 38363) and cyclandelate (October 18, 1984, 49 FR 40972), the Commissioner granted hearings concerning the agency's proposal to withdraw approval of the drugs as lacking substantial evidence of effectiveness. In both cases, the administrative law judge (ALJ) found that the effectiveness of the drugs is not supported by substantial evidence. The affected manufacturers have appealed the ALJ's decision to the Commissioner. Decisions on these drugs will be announced in future Federal Register notices.

(3) Premo Pharmaceutical Laboratories, Inc. (now Lemmon Co., 850 Cathill Rd., Sellersville, PA 18960) (Premo/Lemmon), citing its intent to market nylidrin; and

(4) The National Association of Pharmaceutical Manufacturers (NAPM), 747 Third Ave., New York, NY 10017, on the legal issue of whether the notice revoking the paragraph XIV exemption for peripheral vasodilators discriminated against generic versions of these products. Because the revocation notice did not differentiate between pioneer and generic peripheral vasodilator drug products, NAPM's contention is not discussed further in this order.

The Commissioner of Food and Drugs has considered the arguments and data submitted by USV/Rorer, Cord, and Premo/Lemmon in support of their products or proposed products, and concludes that they are insubstantial and present no genuine issue of material fact justifying a hearing. The arguments and data are discussed below.

I. The Drugs

Each Arlidin Tablet contains either 6 milligrams (mg) or 12 mg of nylidrin hydrochloride. Cord states that its products are identical to USV/Rorer's.

II. Recommended Uses and Dosages

The labeling that is the subject of this proceeding states that Arlidin Tablets are:

"Possibly," effective whenever an increase in blood supply is desirable in vasospastic disorders such as:

Peripheral vascular disease:

Arteriosclerosis Obliterans
Thromboangiitis Obliterans
Diabetic Vascular Disease
Night Leg Cramps
Raynaud's Phenomenon and Disease
Ischemic Ulcer
Frostbite
Acrocyanosis
Acroparesthesia
Thrombophlebitis
Cold Feet, Legs and Hands

Circulatory disturbances of the inner ear:

Primary Cochlear Cell Ischemia
Cochlear Stria Vascular Ischemia
Macular or Ampullar Ischemia and other disturbances due to labyrinthine artery spasm or obstruction

USV/Rorer recommends that a patient take 3 to 12 mg three or four times a day. Cord's product is intended for the same uses and at the same dosages as USV/Rorer's product.

III. Data Submitted to Support Claims of Effectiveness

A. USV/Rorer's Submissions

In response to the notice of opportunity for a hearing, USV/Rorer submitted on July 24, 1979, three controlled studies (Corman, Stambaugh, and Pierce) and nine "partially controlled and uncontrolled" studies to support the use of Arlidin Tablets in treating peripheral vascular disease. The three controlled studies were part of a four-center collaborative study. USV/Rorer did not submit data from the fourth center. In support of the indication for inner ear disturbances, USV/Rorer resubmitted an article—Rubin, W., and J.R. Anderson, "The Management of Circulatory Disturbances of the Inner Ear," *Angiology*, 9:256-261, October 1958—which had been previously evaluated by the NAS/NRC as an uncontrolled study and which had been considered by FDA when it classified Arlidin in 1971 as less-than-effective. USV/Rorer also submitted six published articles as corroborative support for the use of Arlidin in treating inner ear disturbances. In addition to these data, USV/Rorer stated that research was ongoing for the peripheral vascular disease indication and that it planned to sponsor another study on the tinnitus and vertigo indication.

On October 19, 1979, USV/Rorer submitted protocols for: (1) a multicenter study of Arlidin Tablets versus placebo in relieving symptoms of intermittent claudication associated with peripheral vascular disease (Protocol ARL-07), and (2) a study of Arlidin Tablets versus placebo in patients with symptoms of vertigo and tinnitus due to circulatory disturbances of the inner ear (Protocol ARL-06). (Intermittent claudication is characterized as leg (usually calf) pain on exercise.) On May 27, 1980, USV/Rorer submitted a status report on the studies conducted under these protocols. USV/Rorer noted that 27 investigators were participating in the peripheral vascular disease study and 8 investigators were participating in its vertigo/tinnitus study.

On October 21, 1982, USV/Rorer submitted reports on the Protocol ARL-07 and the Protocol ARL-06. The reports included data from 21 investigators who had completed their peripheral vascular disease studies and 8 investigators who had completed their vertigo/tinnitus studies. USV/Rorer claimed that four investigators were continuing their studies on peripheral vascular disease. To date, FDA has not received these data.

The Commissioner has reviewed all data submitted in support of the use of Arlidin for treating peripheral vascular disease and inner ear disturbances, and concludes that the data fail to demonstrate that Arlidin is effective for either disease. A full discussion of these data is provided below.

Prior to discussing these data, however, it should be noted that USV/Rorer also claims that Arlidin is effective for a third indication—treatment of symptoms of the aged. By letters dated March 30 and April 19, 1984, USV/Rorer requested that the agency treat Arlidin's symptoms of the aged indication, which had previously been submitted to FDA as a supplement to the NDA (NDA 9-367), as a DESI indication and that the company be permitted to supplement its pending hearing request with data to support Arlidin's effectiveness for this use. In addition, on July 10, 1980, October 21, 1982, and March 30, April 16, May 3, and June 11, 1984, USV/Rorer supplemented its hearing request with data, information, and analyses intended to support the use of Arlidin in treating symptoms of the aged.

This notice does not discuss the symptoms of the aged indication. The May 25, 1979, notice of opportunity for a hearing proposing to withdraw approval of the NDA for Arlidin Tablets was issued because the drug product was evaluated as lacking substantial evidence of effectiveness for its labeled indications (21 U.S.C. 355(e)). The labeling in use when the agency published the May 1979 notice offered the drug only for treating symptoms of peripheral vascular disease and circulatory disturbances of the inner ear. Because the labeling for Arlidin Tablets did not recommend use in treating symptoms of the aged, this use should be considered a new unapproved use rather than the DESI claim which is the basis of this withdrawal proceeding under 21 U.S.C. 355(e).

USV/Rorer asserts that the treatment of symptoms of aged claim had been included in Arlidin's labeling but that the claim was removed in 1971, following the DESI evaluation of lacking substantial evidence of effectiveness and FDA advice that no additional time would be permitted to conduct studies to support the claim. USV/Rorer maintains that its decision to remove this indication has placed it at a disadvantage compared with other manufacturers of peripheral vasodilators who did not remove comparable claims that are under review in the DESI program.

All manufacturers were notified that failure to delete claims lacking substantial evidence of effectiveness could result in a proceeding seeking to withdraw approval of their NDA's (36 FR 13327, July 20, 1971). Following that notice, USV/Rorer deleted the cerebral vascular disorder claim, which USV/Rorer now characterizes as treatment of symptoms of the aged. In short, USV/Rorer waived its opportunity to contest the withdrawal of the cerebral indication in this proceeding. Fundamental fairness does not require that FDA consider in this proceeding an indication that USV/Rorer deleted from the labeling of Arlidin.

Alternatively, USV/Rorer contends that the deletion of this claim never became effective. By letter dated July 2, 1984, USV/Rorer advised FDA that it would reinstate the cerebral vascular indication for Arlidin on the grounds that the agency had never approved or disapproved the labeling, but merely "permitted" it under 21 CFR 314.8 (d) and (e), formerly 21 CFR 130.9 (d) and (e) (1973). Therefore, the company argues, it is entitled to retract the removal of this indication. The regulation cited by USV/Rorer does not require that FDA take any action when a manufacturer deletes an unsupported claim from its package insert. To the contrary, the regulation provides that such changes take effect prior to FDA's approval. (See current 21 CFR 314.70(c)(2)(iv) (1990).)

In any event, USV/Rorer has not been prejudiced by the failure to consider these data in this proceeding. These data will be reviewed by FDA in the context of a supplemental NDA (as originally intended by USV/Rorer), and the company will be advised of the results of the review.

A review of USV/Rorer's data and claims is as follows:

1. *Treatment of peripheral vascular disease—a. Adequate and well-controlled studies—(1) Corman, Stambaugh, and Pierce studies.* These three double-blind, parallel studies compared Arlidin with placebo in the treatment of intermittent claudication of the lower extremities associated with mild to moderate occlusive arterial disease. All three studies were conducted under a common protocol.

The investigators selected patients who experienced intermittent claudication after walking at least 300 feet and no more than 1,500 feet on a motorized treadmill set at a fixed incline and speed. Patients also had to have diminished pulses in the lower extremities at rest or after exercise, no clinically significant changes in the severity of their symptoms 3 months

prior to entry into the study, and no manifestations of advanced disease.

Each study consisted of an 8-week, single-blind, placebo baseline period followed by a 10-week, double-blind, active medication period. In the active medication period, patients were randomly assigned to an Arlidin treatment group or to a placebo treatment group. During the first 4 weeks of the active medication period, patients took a total daily dose of 24 mg of Arlidin. During the last 6 weeks of the active medication period, these patients took a total daily dose of 48 mg of Arlidin.

Patients were evaluated prior to the placebo baseline period, every 2 weeks during the placebo baseline period and active medication period, and 2 weeks after completing the active medication period. The primary measurement of effectiveness was distance walked on a motorized treadmill. The investigators also measured vital signs, arm blood pressure, and ankle blood pressure; rated the severity of cramps, tightness, tiredness, pain, coldness, and paresthesia; and evaluated the normality of foot skin temperatures, elevation pallor, dependent rubor, and tropic skin changes. These assessments were made throughout the study. At the final office visit the investigators rated each patient's response to medication as "marked improvement," "moderate improvement," "mild improvement," "unchanged," or "worse."

Measurements and ratings performed at the end of the placebo baseline period were used as baseline values.

The protocol entrance criteria also required that onset of claudication (as measured by treadmill walking distance) be stable prior to the active medication period. Patients not meeting this criterion were considered "treadmill criteria violators." USV/Rorer analyzed the data with and without the "treadmill criteria violators."

In the Corman study, USV/Rorer reports that 41 patients entered the study, 3 were excluded as protocol violators, 2 failed to complete the study (their data were analyzed up to the point of dropping out), and 5 were considered "treadmill criteria violators." USV/Rorer concluded that, with and without the "treadmill criteria violators," the Corman study found no statistically significant differences between Arlidin and placebo for any of the effectiveness parameters, except for ankle blood pressure which favored Arlidin ($p < 0.05$) at the end of the low dose active medication period.

In the Stambaugh study, USV/Rorer reported that 41 patients entered the study, 7 were excluded as protocol

violators, 1 failed to complete the study, and 5 were considered "treadmill criteria violators." USV/Rorer concluded that except for foot temperature at the end of the low dose medication period (decreased in the Arlidin group versus no change in the placebo group) and diastolic blood pressure at the end of the high dose medication period (higher after exercise than before exercise in the Arlidin group), there were no significant differences between Arlidin and placebo for any parameter.

In the Pierce study, 39 patients were entered, 15 were excluded as protocol violators, 3 failed to complete the study, and 11 were classified as "treadmill criteria violators." USV/Rorer reported that, with the "treadmill criteria violators" excluded from analysis, there were no significant differences between Arlidin and placebo for any of the effectiveness parameters. USV/Rorer also found that except for pain at the end of the low dose medication period and paresthesia at the end of the high dose medication period (both assessments favoring placebo ($p < 0.05$)), no significant differences were obtained when the "treadmill criteria violators" were included.

In addition to analyzing each study separately, USV/Rorer analyzed the pooled data from all 3 investigators (95 acceptable for evaluation patients). This analysis was also unable to show a difference between Arlidin and placebo for any of the effectiveness parameters.

In conclusion, even adopting USV/Rorer's analyses at face value, the data fail to demonstrate that Arlidin is effective in the treatment of peripheral vascular disease in virtually all effectiveness parameters, including the primary measurement—treadmill walking distance before onset of claudication.

USV/Rorer conceded that the results of these studies are inconclusive. The company contends, however, that many of the patients selected for these studies were in advanced stages of deterioration and no improvement in their conditions could have been reasonably expected. In a later study, discussed next, USV/Rorer designed a protocol to select patients with less advanced disease. The results of this study also failed to demonstrate drug effect.

(2) *Protocol ARL-07.* This was a double-blind, placebo-controlled, parallel, multicenter study intended to compare Arlidin Tablets with placebo in relieving symptoms of intermittent claudication in patients with occlusive arterial disease. This study was

designed in response to the results found in the Corman, Stambaugh, and Pierce studies. USV/Rorer attempted to enter into this study patients suffering from less advanced disease than those selected by Corman, Stambaugh, and Pierce with the expectation that such patients would be better able to respond to Arlidin treatment.

The investigators entered patients diagnosed as having occlusive arterial disease of the lower extremities. These patients also had to experience intermittent claudication after walking more than 350 feet but less than 1,500 feet on a motorized treadmill set at standardized speeds and inclines.

The protocol called for a 2-week training period; a 3-week, single-blind, placebo phase-in period; and a 20-week, double-blind, active treatment period. During the training period, patients practiced walking the motorized treadmill. During the placebo phase-in period, the investigators assessed the patients' signs and symptoms of peripheral vascular disease and their ability to walk the treadmill. Measurements made at the end of this period were used as baseline measurements. At the beginning of the active treatment period, patients were randomly assigned either to Arlidin treatment group (12 mg four times a day) or to a placebo treatment group. Response to medication was evaluated every 2 weeks during the active medication period. Effectiveness assessments included measuring the distance walked on a motorized treadmill, measuring ankle blood pressure, and ratings of various subjective symptoms of peripheral vascular disease, e.g., cramps, tiredness.

USV/Rorer reported that no statistically significant differences were found between Arlidin and placebo, except at week 16 of the active treatment period when placebo was significantly better than Arlidin for walking distance measured on the motorized treadmill ($p < 0.05$).

b. *Partially controlled and uncontrolled studies.* USV/Rorer conceded that the following studies are not adequate and well-controlled clinical investigations. Accordingly, this evidence is incapable of establishing the effectiveness of Arlidin (21 CFR 314.126(e); formerly 21 CFR 314.111(a)(5)(ii)(c)).²

(1) Coffman, J. D., "The Effects of Dichloroisoproterenol, Nylidrin, and Placebo on Peripheral Blood Flow," *Journal of New Drugs*, 3:356-361, November through December, 1963. This study was designed to examine the effects of dichloroisoproterenol, nylidrin, and placebo on skin and muscle blood flow in healthy subjects. The investigator reports that nylidrin caused a significantly greater increase in calf and foot blood flow than placebo. This study is not adequate and well-controlled because it failed to study patients who had the disease condition for which Arlidin is offered (21 CFR 314.126(b)(3); formerly 21 CFR 314.111(a)(5)(ii)(a)(2)(i)).

(2) Spencer, A. M., "Report on a Study of Nylidrin HCl and Vitamin E in the Treatment of Peripheral Vascular Disease," *Journal of the American Podiatry Association*, 51(5):341-344, May 1961. This paper reports the author's experience in treating various symptoms, described as being caused by peripheral vascular disease, with nylidrin hydrochloride, vitamin E, and a combination of the two drugs. The author assigned patients with various symptoms to a nylidrin treatment group (25 patients), a vitamin E-Arlidin combination treatment group (25 patients), a vitamin E treatment group (25 patients), and a placebo treatment group (15 patients). The author reports that 92 percent of the patients treated with Arlidin obtained complete relief or improvement, whereas only one placebo patient showed improvement, nine remained the same, and five became worse.

This study is not adequate and well-controlled for a number of reasons. First, the study report does not provide adequate assurance that the subjects selected for the study were suitable (21 CFR 314.126(b)(3); formerly 21 CFR 314.111(a)(5)(ii)(a)(2)(i)). Although the report claims to have selected patients who exhibited intermittent claudication, night cramps, numbness or paresthesia, cold feet, diabetic and ischemic ulcers, varicose ulcers, thrombophlebitis, and/or frostbite, no diagnostic criteria for these conditions were provided. Moreover, because many of these symptoms alone or in combination could arise from causes other than peripheral vascular disease, there is no assurance that the patients entered in this study had peripheral vascular disease. Even assuming that the patients had peripheral vascular disease, there is no indication that the investigator distinguished between arterial and venous disorders, or between vasospastic, inflammatory, and

occlusive circulatory conditions. It is essential to distinguish between these disorders because a drug may affect these disorders differently.

The study is not adequate and well-controlled for other reasons: patients were not randomly assigned to the treatment groups to minimize bias (21 CFR 314.126(b)(4); formerly 21 CFR 314.111(a)(5)(ii)(a)(2)(ii) and (iii)); the report does not describe the methods of observation and recording of results, including the variables measured and how they were quantitated (21 CFR 314.126(b)(6); formerly 21 CFR 314.111(a)(5)(ii)(a)(3)); and the report does not describe the steps taken to minimize bias on the part of the subjects and observers (21 CFR 314.126(b)(5); formerly 21 CFR 314.111(a)(5)(ii)(a)(3)).

(3) Seligman, B., "A Clinical Assessment of Arlidin in Peripheral Vascular Disease," *Scottish Medical Journal*, 3:173-175, 1958. This paper discusses the results of administering Arlidin to patients diagnosed as having livedo reticulosis and acrocyanosis, chilblains, Raynaud's phenomenon, arteriosclerosis obliterans, lymphoedema praecox, thromboangiitis obliterans, hypertension, or causalgia. This is not an adequate and well-controlled investigation because the effects of treatment with Arlidin are not compared with the effects of treatment with a control (21 CFR 314.126(b)(2); formerly 21 CFR 314.111(a)(5)(ii)(a)(4)).

(4) Klasson, D. H., "Vasodilating Measures in the Treatment of Peripheral Vascular Disease," *Journal of the American Geriatrics Society*, 6(1):33-38, January 1958. This is a general review article that discusses various treatments for peripheral vascular disease. The author also reports that "we have investigated the effectiveness of nylidrin hydrochloride (Arlidin) in a series of 79 cases of peripheral vascular disease, including arteriosclerosis obliterans, Buerger's disease, abdominal aortic occlusion, and chronic venous insufficiency. Clinically, there was improvement in intermittent claudication, rest pain, and edema. There was little change in skin temperature, oscillometric readings or peripheral pulses." The article provides no data, statistical analyses, or other description of the study to support the conclusion. It clearly lacks the details that permit scientific evaluation (21 CFR 314.126(b)(7) and (e); formerly 21 CFR 314.111(a)(5)(ii)(a)(5) and (ii)(c)).

(5) Stein, I. D., "Arlidin: A Clinical Evaluation of a Peripheral Vasodilator with Selective Action on Muscle Vessels," *Annals of Internal Medicine*, 45(2):185-190, August 1956. This article

² On February 22, 1985 (50 FR 7452), FDA published a final rule recodifying and revising the regulations that define an adequate and well-controlled clinical investigation. The Commission includes herein references to the regulations as they now exist and as they existed at the time of the 1979 notice of opportunity for hearing.

reports the results of administering Arlidin to patients diagnosed as having arteriosclerosis obliterans, recent thrombotic closure, or thromboangiitis obliterans. This study is not adequate and well-controlled because the results of treatment with Arlidin are not compared with the results of treatment with a control (21 CFR 314.126(b)(2); formerly 21 CFR 314.111(a)(5)(ii)(a)(4)).

(6) Murphy, H. L., and D. H. Klasson, "Arlidin in the Treatment of Peripheral Vascular Diseases," *New York State Journal of Medicine*, 57(11):1908-1910, June 1957. This article reports the results of administering Arlidin to patients diagnosed as having arteriosclerosis obliterans, thromboangiitis obliterans, abdominal aortic occlusion, postphlebotic syndrome, and chronic lymphoedema. This is not an adequate and well-controlled investigation because the results of treatment with Arlidin are not compared with the results of treatment with a control (21 CFR 314.126(b)(2); formerly 21 CFR 314.111(a)(5)(ii)(a)(4)).

(7) Freedman, L., "Arlidin—A New Vasodilative Sympathomimetic Drug," *Angiology*, 6:52-58, 1955. This article reviews the chemistry, pharmacology, and toxicology of Arlidin. It does not report results from an adequate and well-controlled investigation (21 CFR 314.126; formerly 21 CFR 314.111(a)(5)(ii)).

(8) Jacobson, J.H., and D. Basar, "The Effects of a New Drug, Nyldrin, Upon the Electroretinogram," *AMA Archives of Ophthalmology*, 56(6):865-868, December 1958. This article discusses the effects of Arlidin on retinal blood flow as measured by an electroretinogram. The author reports that administration of Arlidin caused an increase in retinal blood flow. The clinical significance of this pharmacologic effect is not discussed by the author; nor is it known (21 CFR 314.126; formerly 21 CFR 314.111(a)(5)(ii)).

(9) Winsor, T., C. Hyman, and F.M. Knapp, "The Cerebral Peripheral Circulatory Action of Nyldrin Hydrochloride," *American Journal of the Medical Sciences*, 239:594-600, May 1960. This study was undertaken to "describe the circulatory effects of nyldrin hydrochloride in man and animals, and its use in the management of peripheral and cerebral arterial insufficiency." The authors studied:

- i. 25 patients with arteriosclerosis involving the lower extremities and exhibiting intermittent claudication, and
- ii. 5 patients who had "light-headedness or vertigo, mental confusion or diplopia and murmurs over the carotid arteries or other evidence of

cerebral vascular insufficiency." The authors measured pulse rates; blood pressure; cardiac output and stroke volume; heart sounds; blood flow in the calf muscle, fingers, and toes, and peripheral resistance; and conclude that nyldrin hydrochloride increases the blood flow in the calf muscle and in the brain and, to a minimal extent, in the fingers and toes. The authors also report that the drug produced symptomatic clinical improvement when used in the management of cerebral vascular insufficiency and ischemic night leg pain.

This study does not show the effectiveness of Arlidin for any indication. First, the primary assessments—blood flow, pulse rate, and cardiac measurements—are not adequate to show the effect of the drug in treating a peripheral vascular disease or a cerebral vascular disease because they do not show whether the drug improves the clinical condition of the patient. Instead, these measurements show a pharmacologic effect which may or may not correspond with clinical improvement (21 CFR 314.126; formerly 21 CFR 314.111(a)(5)(ii)).

Second, the article fails to provide details on how the study was conducted and, therefore, is not adequate and well-controlled. For example, because the article does not provide the diagnostic criteria for entering patients into the study there is no assurance that the patient selection criteria were suitable (21 CFR 314.126(b)(3) and (b)(4); formerly 21 CFR 314.111(a)(5)(ii)(a)(2)(i) and (a)(5)(ii)(a)(2)(ii)). There is no assurance that patients were randomly assigned to a treatment group and a control group to minimize bias (21 CFR 314.126(b)(4); formerly 21 CFR 314.111(a)(5)(ii)(a)(2)(ii) and (2)(iii)). There is no indication, except in one comparison, that Arlidin had been compared to a control (21 CFR 314.126(b)(2); formerly 21 CFR 314.111(a)(5)(ii)(a)(4)). Even in that one comparison, the results were not quantitatively evaluated (21 CFR 314.126(b)(7); formerly 21 CFR 314.111(a)(5)(ii)(a)(5)).

The article also fails to describe all the symptoms evaluated or how they were quantitated (21 CFR 314.126(b)(6); formerly 21 CFR 314.111(a)(5)(ii)(a)(3)). Nor does it describe the steps taken to minimize bias on the part of the subjects and the observers. Apparently, the study was completely unblinded (21 CFR 314.126(b)(5); formerly 21 CFR 314.111(a)(5)(ii)(a)(3)).

2. *Treatment of circulatory disturbances of the inner ear—*a. *Adequate and well-controlled study—Protocol ARL-06.* This was a double-

blind, parallel, placebo-controlled, multicenter study designed to determine the effectiveness and safety of Arlidin Tablets (6 or 12 mg four times a day) for the treatment of tinnitus and/or vertigo resulting from circulatory disturbances of the inner ear and/or the eighth cranial nerve. Eight investigators enrolled a total of 152 patients, 96 of whom were included in the evaluation of efficacy (70 were evaluated for tinnitus, 4 for vertigo, and 22 for both conditions).

After an initial screening visit, patients entered a 2-week, single-blind, placebo phase-in period during which the patients were seen weekly and the diagnosis of persistent tinnitus and/or vertigo was confirmed. This period was followed by an 8-week, double-blind, active medication period. During the active medication period patients were randomly assigned either to an Arlidin treatment group or to a placebo treatment group. After the active medication period, patients were placed on a 2-week, placebo phase-out period and evaluated weekly. The observations made at the last visit of the placebo phase-in period were used as baseline values.

Evaluations included assessment of tinnitus severity, tinnitus pitch, and vertigo. The investigators rated these symptoms on an 11-point scale (0=absent to 10=severe or high). Statistical comparisons were based on the direction of change (i.e., "less severe," "no change," or "more severe") from baseline at all active medication and followup office visits.

USV/Rorer found no differences between Arlidin and placebo for tinnitus severity at all visits except one (week 6), which favored Arlidin. No significant differences were found between Arlidin and placebo for tinnitus pitch and vertigo severity.

The results of this well-controlled study fail to demonstrate Arlidin's effectiveness in treating tinnitus and/or vertigo. The one isolated positive finding is meaningless considering the overwhelming number of negative findings that show no difference between Arlidin and placebo. USV/Rorer made no effectiveness claims based upon the results of this study and indicated that it had no plans to continue the study of Arlidin for these uses.

b. *Study claimed to be adequate and well-controlled.* Rubin, W., and J.R. Anderson, "The Management of Circulatory Disturbances of the Inner Ear," *Angiology*, 9:256-261, October 1958. This article reports the authors' experience in administering nyldrin

hydrochloride to patients diagnosed as having primary cochlear cell ischemia, cochlear stria vascular ischemia, and macular or ampullar ischemia. The authors report that out of the 75 patients administered nylidrin, 38 responded with complete remission and 32 exhibited hearing improvement as measured audiometrically. The authors state that this represents a success rate of slightly better than 50 percent and that these results are encouraging because they have never been able to achieve more than a 25 percent response with other vasodilators.

Although the NAS/NRC previously characterized this study as uncontrolled, USV/Rorer asserts that the study satisfies the regulatory criteria in 21 CFR 314.111(a)(5)(ii) for an adequate and well-controlled study. For several reasons, the company's contention is demonstrably incorrect.

There is no indication that the study was conducted pursuant to a protocol which included diagnostic criteria to assure the selection of a suitable patient population (21 CFR 314.126 (b)(1) and (b)(3); formerly 21 CFR 314.111 (a)(5)(ii)(a)(1) and (a)(5)(ii)(a)(2)(i)); there is no information regarding the method used to assure the comparability between the test and control groups (21 CFR 314.126(b)(4); formerly 21 CFR 314.111(a)(5)(ii)(a)(2)(ii)); and there is no summary of the methods of analysis or evaluation of the data (21 CFR 314.126(b)(7); formerly 21 CFR 314.111(a)(5)(ii)(a)(5)). While the authors claim to have compared their results with results obtained in patients treated with other vasodilators, the article does not identify the other vasodilators or describe the patients treated or the results of treatment, or compare results quantitatively. Therefore, the contention that the authors' undocumented experience with other vasodilators provides a historical control is without merit (21 CFR 314.126(b)(2); formerly 21 CFR 314.111(a)(5)(ii)(a)(4)). The study is merely additional testimonial evidence that clearly fails to meet the standards of an adequate and well-controlled investigation.

c. Corroborative evidence. The following articles are general review articles that discuss the use of Arlidin or vasodilators in the treatment of ear disorders. USV/Rorer concedes that these data do not constitute adequate and well-controlled investigations (21 CFR 314.126(e); formerly 21 CFR 314.111(a)(5)(ii)(c)).

Cohn, A. M., "Evaluation and Management of the Dizzy Patient," *Southern Medical Journal*, 68(5):584-590, May 1975;

Cracovaner, A. J., "Nonsurgical Management of Meniere's Disease," *New York Journal of Medicine*, 62:1435-1439, May 1962;

Wood, C. D., "Medications for Vertigo and Motion Sickness," *American Journal of Nursing*, 66:1764-1767, August 1966;

Peisel, F. J., "Sudden Hearing Loss: A Medical Emergency," *Journal of the Kentucky Medical Association*, 65:491-492 and 538, May 1967;

Sheehy, J. L., "Vasodilator Therapy in Sensory-Neural Hearing Loss," *Laryngoscope*, 70:885-914, 1960; and

Wilmot, I. J., et al., "Sudden Perceptive Deafness in Young People," *Journal of Laryngology and Otology*, 73:466-468, July 1959.

B. Cord Submission

Cord submitted a general discussion concerning nylidrin hydrochloride that referenced the following published articles:

De Crinis, K., W. Redisch, and J. M. Steele, "Vascular Effects of Nylidrin Hydrochloride During Exercise," *Proceedings of the Society for Experimental Biology and Medicine*, 102:29-31, October-November 1959;

Caliva, F. S., et al., "Some Cardiovascular Effects of Phenyl-2-Butyl-Norsupifen Hydrochloride (Arlidin)," *American Journal of the Medical Sciences*, 238:174-179, December 1959;

Winsor, T., C. Hyman, and F. M. Knapp, "The Cerebral and Peripheral Circulatory Action of Nylidrin Hydrochloride," *American Journal of the Medical Sciences*, 239:594-600, May 1960 (also submitted by USV/Rorer); and

Karpman, H. L., and R. Okun, "The Effect of Vasodilating Drugs in Peripheral Vascular Disease," *Geriatrics*, 27(11):101-107, November 1972.

Cord made no attempt to comply with FDA regulations that require a point-by-point explanation on how the studies comply with each criterion of the regulations for adequate and well-controlled clinical investigations (21 CFR 314.200(d)). Because Cord has not complied with the content and format requirements of FDA's hearing regulations, the Commissioner is not obligated to review the firm's hearing request (21 CFR 314.200(d)(3) (1990)); formerly 21 CFR 314.200(d)(3) (1979)).

Nevertheless, the submission has been reviewed and is conclusively deficient. The first two references are not clinical studies. Rather, they involve pharmacologic measures which may or may not relate to the clinical condition of a patient (21 CFR 314.126; formerly 21 CFR 314.111(a)(5)(ii)). The third

reference (reviewed in detail under "USV/Rorer Submissions" above) reports on a pharmacologic study with secondary, unsupported clinical observations that are not gathered in a controlled study. The fourth article reports on a study that lacks a control group (21 CFR 314.126(b)(2); formerly 21 CFR 314.111(a)(5)(ii)(a)(4)).

C. Premo/Lemmon Submission

Premo/Lemmon did not submit any data or analyses in support of its hearing request as required by 21 CFR 314.200 (d) or (e).

D. Summary of Submissions

USV/Rorer submitted four well-controlled clinical investigations concerning the use of Arlidin Tablets in treating arteriosclerosis obliterans (Corman, Stambaugh, Pierce, and Protocol ARL-07). None of these studies was able to significantly distinguish Arlidin Tablets from placebo. The firm also submitted one well-controlled, eight-investigator study concerning the use of Arlidin Tablets in treating persistent tinnitus and/or vertigo (Protocol ARL-06). This study also failed to distinguish Arlidin Tablets from placebo. Thus, all of the well-controlled studies failed to demonstrate the effectiveness of Arlidin.

USV/Rorer also submitted one published article by Rubin and Anderson to support the use of Arlidin in treating "circulatory disturbances of the inner ear." This article reports on an uncontrolled study that is conclusively inadequate to support the effectiveness of Arlidin for any indication. The other references submitted by USV/Rorer are, by the company's own evaluations, not adequate and well-controlled clinical investigations and, therefore, cannot provide substantial evidence of effectiveness (21 CFR 314.126(e); formerly 21 CFR 314.111(a)(5)(ii)(c)).

Cord cited two pharmacologic studies; one pharmacologic study with secondary, unsupported clinical observations; and one study that lacked controls. These studies are conclusively inadequate to support the effectiveness of nylidrin hydrochloride to treat any disease or condition.

Premo/Lemmon did not submit any data.

IV. Legal Arguments

USV/Rorer and Cord assert that their submissions raise a genuine issue of fact requiring a hearing. USV/Rorer's submission contains many studies that are conclusively inadequate and not well-controlled, and several well-controlled studies that fail on their face

to show that Arlidin is effective for its labeled indications. Cord's submission contains conclusively inadequate studies. To hold a hearing on these submissions would be fruitless.

Weinberger v. Hynson, Westcott & Dunning, Inc., 412 U.S. 609, 620 (1973); *Cooper Laboratories, Inc. v. Commissioner, Food and Drug Administration*, 501 F.2d 772, 785 (D.C. Cir. 1974); *Holland-Rantos Co., Inc., v. U.S. Department of HEW*, 587 F.2d 1173, DC Cir. 1978.

USV/Rorer argues that denial of a hearing is improper because it has submitted expert opinions supporting the efficacy of Arlidin Tablets. The company contends that these opinions raise a material dispute that must be resolved by a trier of fact. This contention was rejected by the Supreme Court when it held that testimonial evidence cannot constitute proof of drug efficacy that warrants an evidentiary hearing. *Weinberger v. Hynson, Westcott & Dunning, Inc.*, *supra* at 619, 630. See also, e.g., *United States v. 225 Cartons*, 871 F.2d 409, 419 (3d Cir. 1989) (granting summary judgment and condemning new drug despite expert testimony of drug manufacturer).

USV/Rorer contends that it has not had adequate notice of the deficiencies in its submissions and that it has been improperly denied an opportunity to respond to FDA criticisms before a final decision of the Commissioner. Cord and Premo/Lemmon also argue that the notice of opportunity for hearing failed to provide adequate information for them to respond.

These arguments are untenable. The May 25, 1979, notice of opportunity for a hearing provided a specific notice to USV/Rorer and all other interested parties that no adequate and well-controlled investigations meeting the criteria of 21 CFR 314.126 (formerly 21 CFR 314.111(a)(5)) had been submitted to support the effectiveness of nylidrin hydrochloride. It is now settled that this procedure provides adequate notice to the manufacturers and is perfectly permissible. As the U.S. Supreme Court stated long ago:

The standard of 'well-controlled investigations' particularized by the regulations is a protective measure designed to ferret out those drugs for which there is no affirmative, reliable evidence of effectiveness. *The drug manufacturers have full and precise notice of the evidence they must present to sustain their NDA's*, and under these circumstances we find FDA hearing regulations unexceptional on any statutory or constitutional ground.

Weinberger v. Hynson, Westcott & Dunning, Inc., *supra* at 622 (emphasis added).

USV/Rorer next argues that FDA's revocation of the paragraph XIV exemption is illegal because it was not in accord with the agency's Compliance Policy Guide (CPG) 7132c.08 B-I (1976) now CPG 7132c.02 (1987), which states that FDA would announce in the **Federal Register** the availability of guidelines describing the design of clinical studies before a paragraph XIV exemption may be revoked.

This argument is without merit. First, the guidelines on the design of clinical studies for peripheral vasodilators have been publicly available since 1974 (44 FR 30443, May 25, 1979), and USV/Rorer followed these guidelines in some of its studies. USV/Rorer's failure to show the effectiveness of Arlidin was not due to its inability to design adequate studies. Indeed, the denial of the company's hearing request is, in part, based on the complete failure of adequately designed studies to prove effectiveness. Secondly, by its own terms, the CPG applies to "Marketed New Drugs Without Approved NDA's or abbreviated NDA's" (emphasis added). Arlidin was marketed with an approved NDA, and thus was not covered by the CPG.

USV/Rorer argues that the revocation of Arlidin's exemption status under paragraph XIV was procedurally defective because the revocation is a "rule" within the meaning of the Administrative Procedure Act, and the revocation was issued in final form without the required notice and comment procedure. Premo/Lemmon also questions whether it was proper to revoke the exemption without prior notice.

These arguments are based on a misinterpretation of the paragraph XIV exemption. The paragraph XIV exemption is not an agency-created exemption. Rather, it is part of an order entered by the court in *American Public Health Ass'n v. Veneman*, 349 F. Supp. 1311 (D.D.C. 1972), that directed the agency, pursuant to the schedule established by the court, to initiate proceedings to remove from the market drug products not proven to be effective. Paragraph XIV of the order permitted the agency to exercise its discretion and temporarily delay such proceedings for a limited number of drugs provided there were a compelling justification of their medical need and a likelihood that additional data regarding effectiveness would be developed.

More importantly, the paragraph XIV exemption conferred no new rights on the products affected by it, but merely preserved administrative flexibility and discretion when to initiate proceedings against violative products. New drug products like Arlidin were placed in

paragraph XIV by FDA without notice and comment, and there is no legal or logical reason why such products cannot be removed from paragraph XIV without prior notice.

USV/Rorer requested that a decision on its hearing request be deferred until completion of its ongoing studies. The Commissioner concludes that USV/Rorer has had ample opportunity (more than 10 years) to present data in support of Arlidin, and further delay is inappropriate.

Finally, Premo/Lemmon contends that nylidrin hydrochloride is not a new drug and that there is substantial evidence of effectiveness for the drug. Premo/Lemmon did not submit any data or information to support these general contentions as required by 21 CFR 314.200. Therefore, this argument is rejected.

V. Findings

On the basis of the foregoing, the Commissioner finds that there is a lack of substantial evidence that Arlidin Tablets or any drug product containing nylidrin hydrochloride has the effects it is represented to have under the conditions of use prescribed, recommended, or suggested in its labeling. Furthermore, USV/Rorer, Cord, and Premo/Lemmon have failed to show that there is a genuine and substantial issue of fact requiring a hearing.

Therefore, under the Federal Food, Drug, and Cosmetic Act (sec. 505(e) (21 U.S.C. 355(e)) and under authority delegated to the Commissioner of Food and Drugs (21 CFR 5.10), the requests for a hearing are denied and approval of NDA 9-367 for Arlidin Tablets, and all amendments and supplements thereto, is withdrawn effective December 26, 1991. Arlidin's supplemental NDA (S-021) concerning the use of Arlidin in treating symptoms of the aged is not covered by this notice. However, as discussed earlier, because the supplemental NDA has not been approved and is not based upon a DESI claim, USV/Rorer is not entitled to market Arlidin for use in treating symptoms of the aged. Accordingly, shipment of all drug products containing nylidrin hydrochloride in interstate commerce after December 26, 1991, will be unlawful and subject to regulatory action.

Dated: November 18, 1991.

David A. Kessler,

Commissioner of Food and Drugs.

[FR Doc. 91-28218 Filed 11-22-91; 8:45 am]

BILLING CODE 4160-01-M

DEPARTMENT OF THE INTERIOR**Bureau of Land Management****Notice of Advisory Council Meeting**

AGENCY: Bureau of Land Management, Interior.

ACTION: Meeting of Coos Bay District Advisory Council.

SUMMARY: Notice is hereby given in accordance with Public Law 94-579 and 43 CFR, part 1780 that a meeting of the Coos Bay District Advisory Council will be held on Monday, December 9, 1991, beginning at 1 p.m. The meeting will be held in the Coos Bay District Office, 1300 Airport Lane, North Bend, Oregon.

AGENDA: The agenda for the meeting will include:

1. Discussion of the RMP schedule and update of the current status of the planning effort.
2. Discussion of the FY 1992 budget.
3. Updates on specific projects.
4. Arrangements for the next meeting.

The meeting is open to the public and news media. Interested persons may make oral statements to the council between 1:30 p.m. and 2 p.m. on Monday, December 9, or file written statements for the council's consideration.

ADDRESSES: Bureau of Land Management, Coos Bay District Office, 1300 Airport Lane, North Bend, OR 97459.

Minutes of the meeting will be maintained at the District Office and made available during regular business hours (7:45 a.m. to 4:30 p.m.) for public inspection or reproduction at the cost of duplication.

Dated: October 28, 1991.

Melvin E. Chase,
District Manager.

[FR Doc. 91-28352 Filed 11-21-91; 8:45 am]

BILLING CODE 4310-33-M

[ID-040-4410-08]

Resource Management Plan; Challis Resource Area Lemhi and Custer Counties, ID

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of intent to initiate a Resource Management Plan (RMP) and prepare an Environmental Impact Statement (EIS) for the Challis Resource Area in Lemhi and Custer Counties, Idaho and invitation to participate in the identification of issues (scoping).

SUMMARY: Pursuant to section 202 of the Federal Land Policy and Management

Act of 1976 (FLPMA) and section 102(2)(C) of the National Environmental Policy Act of 1969 (NEPA), the Bureau of Land Management (BLM), Salmon District will prepare a Resource Management Plan (RMP) and an Environmental Impact Statement (EIS) for the Challis Resource Area in Lemhi and Custer Counties, Idaho. The Resource Management Plan will guide resource management in the Challis Resource Area over the next 15 to 20 years. The plan will be prepared under guidance provided in BLM planning regulations (43 CFR part 1600). The public, State and local governments, other Federal agencies, and Indian tribes are invited to participate in the planning process.

DATES: Any public meetings pursuant to 40 CFR 1501.7 (NEPA regulations) and 43 CFR 1610.2 (BLM planning regulations) to help identify and determine the issues to be addressed and the scope of the RMP and EIS will be announced in the local media and through a mailing list. Some local meetings have been held within the past few weeks pertaining to this RMP and EIS, and were announced in the local media and through a mailing list. Specific dates and locations for additional meetings have not yet been determined. To receive maximum consideration, comments should be received in the Bureau of Land Management office in Salmon, ID by January 10, 1992.

ADDRESSES: Comments should be sent to: Challis Resource Area Manager, Bureau of Land Management, P.O. Box 430, Salmon, ID 83467.

FOR FURTHER INFORMATION CONTACT: Mark Johnson, Challis Resource Area Manager, Bureau of Land Management, P.O. Box 430, Salmon, ID 83467, or telephone (208) 756-5400. Documents relevant to this planning process will be maintained at the Challis Resource Area Office at the above address and are available for public viewing during normal office hours.

SUPPLEMENTARY INFORMATION: The Challis Resource Area includes approximately 788,500 acres of public land located in Lemhi and Custer Counties. It commences on the north at approximately the Hat Creek drainage, and extends southward to include the public lands in the Pahsimeroi Valley the Big Lost River Valley to Mackay, and the Main and East Fort Salmon River Valleys. The planning area is bordered almost exclusively by National Forest System lands. The planning process (which will include the NEPA process) will evaluate a range of alternative resource uses for this area

and will address issues identified during the scoping process.

Potential issues to be addressed during the process include, but are not limited to, vegetation management, including soil and watershed protection, habitat structure, forage, critical plant habitat, and forest; land tenure adjustments; water-related resources such as anadromous fish habitat and water quality concerns of the Clean Water Act; consideration of areas for special designation such as Areas of Critical Environmental Concern; and eligibility determination and tentative classification of Wild, Scenic, or Recreational river segments in compliance with the Wild and Scenic Rivers Act (as amended). Following tentative classification, some priority river segments will also be evaluated for suitability for inclusion into the Wild and Scenic Rivers System.

The RMP and EIS will be prepared by an interdisciplinary team primarily from within the Challis Resource Area and Salmon District Office staff. Additional technical support and expertise will be provided by BLM staff at the Idaho State Office and Idaho Falls Office, as needed.

Public participation will occur throughout the planning process. The public will be specifically invited to participate during four steps in the planning process: (1) Identification of issues, (of which this notice is a part), (2) review of proposed planning criteria, (3) review of Draft RMP/EIS, and (4) review of Proposed Plan/Final EIS. Invitations for public participation will be announced through the local media and our mailing list. The planning process is currently scheduled for completion in approximately three years.

Dated: November 1, 1991.

Roy S. Jackson,
District Manager.

[FR Doc. 91-28228 Filed 11-22-91; 8:45 am]

BILLING CODE 4310-GG-M

Fish and Wildlife Service**Notice of Receipt of Application for Permit**

The public is invited to comment on the following application for a permit to conduct certain activities with marine mammals. The application was submitted to satisfy requirements of the Marine Mammal Protection Act of 1972, as amended (16 U.S.C. 1361 *et seq.*), and the regulations governing marine mammals (50 CFR part 18).

Applicant: Dr. Donald B. Siniff, 109 Zoology Building, 318 Church Street, SE, University of Minnesota, Minneapolis, MN 55455. File No. PRT-763537.

Type of Permit: Scientific Research.

Name and Number of Animals:

Alaskan sea otter (*Enhydra lutris*) 300.

Summary of Activity to be

Authorized: The applicant proposes to take these animals for scientific research. Activities will include capture, tagging, surgical implants, take of biological samples, and release.

Source of Marine Mammals for Research: Wild animals taken from nearshore waters of Amchitka Island, AK.

Period of Activity: Capture is proposed to begin in June 1992 and continue through December 1994. 2 years.

Concurrent with the publication of this notice, the Office of Management Authority is forwarding copies of the application to the Marine Mammal Commission and the Committee of Scientific Advisors for their review.

Written data or comments and/or requests for a public hearing on this application should be submitted to the Director, U.S. Fish and Wildlife Service, Office of Management Authority, 4401 North Fairfax Drive, room 432, Arlington, Virginia 22203 and must be received by the Director within 30 days of the date of this publication. Anyone requesting a hearing should give specific reasons why a hearing would be appropriate. The holding of such a hearing is at the discretion of the Director.

Documents and other information submitted with this application are available for review by any party who submits a written request for a copy of such documents to, or by appointment during normal business hours (7:45-4:15) in, the following office within 30 days of the date of publication of this notice: U.S. Fish and Wildlife Service, Office of Management Authority, 4401 North Fairfax Drive, room 432, Arlington, Virginia 22203. Phone: (703/358-2104); FAX: (703/358-2281)

Dated: November 19, 1991.

Maggie Tieger,

Chief, Branch of Permits, Office of Management Authority.

[FR Doc. 91-28207 Filed 11-22-91; 8:45 am]

BILLING CODE 4310-55-M

National Park Service

National Register of Historic Places; Notification of Pending Nominations

Nominations for the following properties being considered for listing in

the National Register were received by the National Park Service before November 9, 1991. Pursuant to § 60.13 of 36 CFR part 60 written comments concerning the significance of these properties under the National Register criteria for evaluation may be forwarded to the National Register, National Park Service, P.O. Box 37127, Washington, DC 20013-7127. Written comments should be submitted by December 10, 1991.

Carol D. Shull,

Chief of Registration, National Register.

IOWA

Allamakee County

Lansing Fisheries Building (Conservation Movement in Iowa MPS), Between Co. Hwy. X-52 and the Mississippi R., south Lansing, Lansing, 91001832

Calhoun County

Holdegel, Perry C. and Mattie Forrest, House (Conservation Movement in Iowa MPS), 504 Eighth St., Rockwell City, 91001831

Clayton County

American School of Wild Life Protection Historic Districts (Conservation Movement in Iowa MPS), McGregor Heights Rd., N of McGregor, McGregor vicinity, 91001840
Guttenberg National Fish Hatchery and Aquarium Historic District (Conservation Movement in Iowa MPS), 315 S. River Park Dr., Guttenberg, 91001833

Decatur County

Missouri, Iowa & Nebraska Railway Co. Depot—Weldon (Advent & Development of Railroads in Iowa MPS), N. Main St. at Decatur County line, Weldon, 91001827

Delaware County

Backbone State Park Historic District (Conservation Movement in Iowa MPS; CCC Properties in Iowa State Parks MPS), Jct. of Co. Rds. C57 and W69, Strawberry Point vicinity, 91001842

Dickinson County

Iowa Lakeside Laboratory Historic District (Conservation Movement in Iowa MPS), IA 86 about 4 mi. N-NW of jct. with US 71, Milford vicinity, 91001830

Franklin County

Boehmler, H. E., House, 105 2nd St., SE., Hampton, 91001829
Franklin County G. A. R. Soldiers' Memorial Hall, 3 Federal St. N., Hampton, 91001828

Greene County

Squirrel Hollow County Park Historic District (Conservation Movement in Iowa MPS), E bank of N. Raccoon R. SE of Jefferson, Jefferson vicinity, 91001835

Jackson County

Maquoketa Caves State Park Historic District (Conservation Movement in Iowa MPS; CCC Properties in Iowa State Parks MPS), Co. Rd. 428 NW of Maquoketa, Maquoketa vicinity, 91001843

Johnson County

Shimek, Bohumil, House (Conservation Movement in Iowa MPS), 529 Brown St., Iowa City, 91001837

Monona County

Jones Creek Watershed Historic District (Conservation Movement in Iowa MPS), Between Little Sioux and Soldier Rivers, SW of Moorhead, Moorhead vicinity, 91001839

Polk County

Darling, Jay Norwood and Genevieve Pendleton, House (Conservation Movement in Iowa MPS), 2320 Terrace Rd., Des Moines, 91001838
Fish and Games Pavilion and Aquarium (Conservation Movement in Iowa MPS; Architectural Legacy of Proudfoot & Bird in Iowa MPS), Iowa States Fairgrounds, Des Moines, 91001836

Sac County

Lakeside Park Historic District (Conservation Movement in Iowa MPS; CCC Properties in Iowa State Parks MPS), Third St. from Lake to Park St., Lake View, 91001841

LOUISIANA

Lincoln Parish

Ruston P.O.W. Camp Buildings, LA 150, Ruston vicinity, 91001825

MAINE

Cumberland County

Maplewood Farm, River Rd. SE of jct. with Hebbard Rd., South Windham vicinity, 91001813

Lincoln County

Fort Edgecomb, Address Restricted, Edgecomb vicinity, 91001814

Sagadahoc County

Coombs, Viola, House, Main St., Bowdoinham, 91001816

Waldo County

East Main Street Historic District, US 1 between Black Rd. and Navy St., Searsport, 91001815

York County

Fogg, William, Library (Main Public Libraries MPS), Old Rd., Eliot vicinity, 91001817

MASSACHUSETTS

Berkshire County

Park Square Historic District (Boundary Increase), Roughly bounded by E. Housatonic, South, North and Fenn Sts. and Wendell Ave., Pittsfield, 91001826

Hampshire County

North Amherst Center Historic District,
1184—1136 N. Pleasant St., 1—39 Pine St.,
11—13 Meadow St.,
Amherst vicinity, 910018 24

NORTH CAROLINA**Guilford County**

South Greensboro Historic District
(Greensboro MPS),
Roughly bounded by Gorrell, Martin, E.
Bragg, Sevier, Omaha, Broad, Caldwell,
Andrew, Vance, McCulloch, and King Dr.,
Greensboro, 91001812

TEXAS**Taylor County**

Abilene Commercial Historic District
(Abilene MPS),
Roughly bounded by Hickory, N. Third and
Pine Sts. and the S side of the Missouri
Pacific RR tracks, Abilene, 91001811

UTAH**Davis County**

VanFleet Hotel,
88 E. State St.,
Farmington, 91001819

Utah County

Alpine City Hall
(Public Works Buildings TR),
20 N. Main St.,
Alpine, 91001820
Springville Carnegie Library
(Carnegie Library TR),
175 S. Main St.,
Springville, 91001821

Weber County

Scowcroft, Heber, House,
795 24th St.,
Ogden, 91001818

WISCONSIN**Milwaukee County**

LIGHT VESSEL No. 57,
Milwaukee Harbor,
Milwaukee vicinity, 91001823

Trempealeau County

Trempealeau Platform Mounds Site,
Address Restricted,
Trempealeau, 91001822
[FR Doc. 91-28178 Filed 11-22-91; 8:45 am]
BILLING CODE 4310-70-M

**INTERNATIONAL DEVELOPMENT
COOPERATION AGENCY****Agency for International Development;
International Disaster Advisory
Committee Meeting**

The International Disaster Advisory
Committee (IDAC) will hold a meeting
on Wednesday, December 11, 1991.
Topics for discussion will include
corporate-government cooperation for
international disaster mitigation,
prevention and response.

Date: December 11, 1991.

Time: 2 p.m.—4 p.m.

Place: Old Executive Office Building,
17th and Pennsylvania Avenue,
Washington, DC.

The meeting is free and open to the
Public. However, notification by
November 29, 1991 through the Advisory
Committee Office is required.

Persons wishing to attend the meeting
must call Susan Grindler (202) 647-5210
before November 29, 1991, or write to be
received by that date to: International
Disaster Advisory Committee, Agency
for International Development, room
1262A NS, Washington, DC 20523-0008.

Dated: November 14, 1991.

Oliver R. Davidson,

Executive Director, International Disaster
Advisory Committee.

[FR Doc. 91-28174 Filed 11-22-91; 8:45 am]

BILLING CODE 6110-01-M

**INTERSTATE COMMERCE
COMMISSION**

[Docket No. AB-338 (Sub-No. 1X)]

**Oregon, California & Eastern Railway
Co.—Abandonment Exemption—in
Klamath County, OR**

AGENCY: Interstate Commerce
Commission.

ACTION: Notice of exemption.

SUMMARY: Pursuant to 49 U.S.C. 10505,
the Commission exempts from the prior
approval requirements of 49 U.S.C.
10903, *et seq.*, Oregon, California &
Eastern Railway Company's (OC&E): (1)
abandonment of its 65.4-mile line of
railroad between milepost 0.0, near
Klamath Falls and milepost 65.4, near
Bly, OR; and (2) discontinuance of
bridge trackage rights over
approximately 4.5 miles of rail line of
the Burlington Northern Railroad
Company (BN) and the Southern Pacific
Transportation Company (SP). The
trackage for which an abandonment
exemption is sought, as well as the
trackage over which discontinuance of
trackage rights is sought to be exempted,
is located entirely within Klamath
County, OR. The exemption is subject to
three stipulations. These are (1) the
requirement that OC&E will: (a) Use
existing access routes to and from the
abandoned railroad line during salvage
operations; (b) confine the salvage
operations to the existing railroad right-
of-way; and (c) dispose of all railroad
ties and iron track in an approved
manner; (2) the requirement that the
railroad comply with the terms and

conditions for implementing interim trail
use/rail banking; and (3) the condition
that, if a trail use agreement is reached
on any portion of the right-of-way,
OC&E must keep intact the remainder of
the right-of-way underlying the track for
a period of 180 days from the effective
date of this decision in order to enable
any State or local government agency,
or other interested person, to negotiate
the acquisition of the right-of-way for
public use.

DATES: Provided no formal expression of
intent to file an offer of financial
assistance is received, this exemption
will be effective on December 25, 1991.
Formal expressions of intent to file an
offer¹ of financial assistance under 49
CFR 1152.27(c)(2) must be filed by
December 5, 1991. Petitions for stay
must be filed by December 10, 1991, and
petitions for reconsideration must be
filed by December 20, 1991. Requests for
an interim trail use or public use
condition must be filed by December 5,
1991.

ADDRESSES: Send pleadings referring to
Docket No. AB-338 (Sub-No. 1X) to:

- (1) Office of the Secretary, Case Control
Branch, Interstate Commerce
Commission, Washington, DC 20423
and
- (2) Petitioner's representative:
Christopher Eric Hagerup, Suite 800,
1350 New York Avenue, NW.,
Washington, DC 20005.

FOR FURTHER INFORMATION CONTACT:
Joseph H. Dettmar, (202) 275-7245 [TDD
for hearing impaired: (202) 275-1721].

SUPPLEMENTARY INFORMATION:

Additional information is contained in
the Commission's decision. To purchase
a copy of the full decision, write to, call,
or pick up in person from: Dynamic
Concepts, Inc., room 2229, Interstate
Commerce Commission Building,
Washington, DC 20423. Telephone: (202)
289-4357/4359. [Assistance for the
hearing impaired is available through
TDD services (202) 265-1721.]

Decided: November 13, 1991.

By the Commission, Chairman Philbin, Vice
Chairman Emmett, Commissioners Simmons,
Phillips, and McDonald.

Sidney L. Strickland, Jr.,

Secretary.

[FR Doc. 91-28245 Filed 11-22-91; 8:45 am]

BILLING CODE 7035-01-M

¹ See Exempt. of Rail Line Abandonment-Offers of
Finan. Assist., 4 I.C.C.2d 164 (1987), and final rules
published in the Federal Register on December 27,
1987 (52 FR 48440-48446).

DEPARTMENT OF JUSTICE

Lodging of Consent Decree Pursuant to the Clean Air Act

In accordance with Departmental policy, set out in 28 CFR 50.7, notice is hereby given that on November 7, 1991, a proposed consent decree in settlement of *United States v. State of Hawaii Department of Transportation*, Civil Action No. 91-00629 HMF, was lodged with the United States District Court for the District of Hawaii. The Complaint sought penalties and injunctive relief against Associates Four for violations of the asbestos NESHAPS regulations regarding notification, handling and disposal of friable asbestos-containing material during the demolition of a facility at Honolulu International Airport, Honolulu, Hawaii. The proposed settlement imposes a civil penalty of \$20,000.00 for the violations.

The Department of Justice will receive for a period of thirty (30) days from the date of this publication, comments relating to the proposed Consent Decree. Comments should be addressed to the Assistant Attorney General of the Environment and Natural Resources Division, Department of Justice, P.O. Box 7611, Washington, DC 20044. Comments should refer to *United States v. State of Hawaii Department of Transportation*, D.J. Ref. No. 90-5-2-1-1398.

The proposed Consent Decree may be examined at the Environmental Enforcement Section Document Center, 601 Pennsylvania Ave., NW., Box 1097, Washington, DC 20004, telephone (202) 347-7829 at the Office of the United States Attorney, District of Hawaii, room C-242, PJKK Federal Building, 300 Ala Moana Blvd., Honolulu, HI 96850, and at the offices of the Environmental Protection Agency, Region 9, 75 Hawthorne Street, San Francisco, CA 94105.

A copy of the proposed Consent Decree may be obtained in person or by mail from the Environmental Enforcement Document Center. In requesting a copy, please enclose a check in the amount of \$5.25 (25 cents per page reproduction cost) payable to the "Consent Decree Library".

John C. Cruden,
Environmental Enforcement Section,
Environment and Natural Resources Division.
[FR Doc. 91-28176 Filed 11-22-91; 8:45 am]

BILLING CODE 4410-01-M

DEPARTMENT OF LABOR

Office of the Secretary**Agency Recordkeeping/Reporting Requirements Under Review by the Office of Management and Budget (OMB)****Background**

The Department of Labor, in carrying out its responsibilities under the Paperwork Reduction Act (44 U.S.C. Chapter 35), considers comments on the reporting/recordkeeping requirements that will affect the public.

List of Recordkeeping/Reporting Requirements Under Review: As necessary, the Department of Labor will publish a list of the Agency recordkeeping/reporting requirements under review by the Office of Management and Budget (OMB) since the last list was published. The list will have all entries grouped into new collections, revisions, extensions, or reinstatements. The Departmental Clearance Officer will, upon request, be able to advise members of the public of the nature of the particular submission they are interested in.

Each entry may contain the following information:

- The Agency of the Department issuing this recordkeeping/ reporting requirement.
- The title of the recordkeeping/reporting requirement.
- The OMB and/or Agency identification numbers, if applicable.
- How often the recordkeeping/reporting requirement is needed.
- Whether small businesses or organizations are affected.
- An estimate of the total number of hours needed to comply with the recordkeeping/ reporting requirements and the average hours per respondent.
- The number of forms in the request for approval, if applicable.
- An abstract describing the need for and uses of the information collection.

Comments and Questions: Copies of the recordkeeping/reporting requirements may be obtained by calling the Departmental Clearance Officer, Kenneth A. Mills ((202) 523-5095). Comments and questions about the items on this list should be directed to Mr. Mills, Office of Information Resources Management Policy, U.S. Department of Labor, 200 Constitution Avenue, NW., Room N-1301, Washington, DC 20210. Comments should also be sent to the Office of Information and Regulatory Affairs, Attn: OMB Desk Officer for (BLS/DM/ESA/ETA/OLMS/MSHA/OSHA/PWBA/VETS), Office of Management and Budget, Room 3001, Washington, DC 20503 ((202) 395-6880).

Any member of the public who wants to comment on recordkeeping/ reporting requirements which have been submitted to OMB should advise Mr. Mills of this intent at the earliest possible date.

Extension*Employment and Training Administration***State Plan and Subgrantee Plan for EDWAA**

1205-0273

Biennially

State or local governments

59 respondents; 1,180 total hours; 20 hrs. per response

No forms

The State Plan, required by section 311(a) and the plan required by section 311(b) of JTPA as amended by subtitle D of title VI of the Omnibus Trade and Competitiveness Act of 1988 (Pub.L. 100-418) will provide the Department of Labor with a general description of each State's plan for the operation of the EDWAA program and its utilization of JTPA funds for this purpose.

*Employment Standards Administration***Health Insurance Claim Form**

1215-0055

OWCP 1500

On occasion

Individuals or households; State or local governments; Businesses or other for-profit; Federal agencies or employees; non-profit institutions; Small businesses or other organizations 634,000 respondents; 157,167 total hours; 5/15 min. per response

1 form

OWCP 1500 is a standard form used by all medical providers (except pharmacies) to request payment for FECA and FBLA claimants' treatment for industrial injury and disease.

Resubmission Turnaround Document

1215-0177

CM-1173

On occasion

Individuals or households; State or local governments; Businesses or other for-profit; Federal agencies or employees; Non-profit institutions; Small businesses or organizations 30,000 respondents; 2,500 total hours; 5 min. per response

1 form

The Resubmission Turnaround Document collects missing information for the Black Lung portion of the OWCP 82 and OWCP 1500.

Uniform Health Insurance Claim Form

1215-0176

OWCP 82

On occasion

Individuals or households; State or local governments; Businesses or other for-profit; Federal agencies or employees; Non-profit Institutions; Small businesses or organizations

97,000 respondents; 21,350 total hours; 9 to 17 min. per response

1 form

The OWCP 82 is used by providers to bill OWCP for inpatient care provided to claimants.

1215-0038

WH-510-MIS

Annually

Individuals or households; Farms;

Businesses or other for profits; Small businesses or organizations

6,600 respondents; 3,300 total hours; 30 minutes per response

1 form

The Migrant and Seasonal Agricultural Worker Protection Act provides that no individual may perform farm labor contracting activities without a certificate of registration. Form WH-510-MIS is the application form which provides the Department of Labor with the information necessary to issue a certificate specifying the farm labor contracting activities authorized.

Signed at Washington DC this 19th day of November, 1991.

Kenneth A. Mills,

Departmental Clearance Officer.

[FR Doc. 91-28214 Filed 11-22-91; 8:45 am]

BILLING CODE 4510-27-M

Employment and Training Administration

[TA-W-26,354]

Chicago Pneumatic Tool Co., Utica, NY; Termination of Investigation

Pursuant to section 221 of the Trade Act of 1974, an investigation was initiated on September 23, 1991 in response to a worker petition which was filed on September 23, 1991 on behalf of workers at Chicago Pneumatic Tool Company, Utica, New York.

The petitioner has requested that the petition be withdrawn. Consequently, further investigation in this case would serve no purpose, and the investigation has been terminated.

Signed at Washington, DC, this 15th day of November, 1991,

Marvin M. Fooks,

Director, Office of Trade Adjustment Assistance.

[FR Doc. 91-28212 Filed 11-22-91; 8:45 am]

BILLING CODE 4510-30-M

[TA-W-23,929]

Chrysler Corp., St. Louis #1, Fenton, MO; Revised Determination on Reconsideration

Pursuant to a court remand in *International Union, UAW and UAW Local 136 v. Secretary of Labor* (USCIT 90-07-00325), the Department is revising its initial denial of eligibility to workers of the St. Louis #1 plant of Chrysler Corporation in Fenton, Missouri.

The court remand provided an additional time for plaintiffs to submit additional material for the record showing where the Department's findings are not supported by substantial evidence especially concerning the vehicles to be included and excluded in the Department's market classification system.

On reconsideration, the Department accepts the union's material and agrees that its analysis should be modified accordingly.

New data shows that the Chevrolet Beretta has characteristics which are like the subject vehicles (Dodge Daytona and Chrysler LeBaron) and should have been included in the Department's market analysis. Further, the new market analysis shows that the market share captured by imports increased importantly while the subject models share declined.

Production of the subject vehicles at St. Louis #1 decreased in calendar year (CY) 1989 compared to CY 1988. Substantial worker separations occurred in 1989 compared to 1988.

Conclusion

After careful review of the additional facts obtained on reconsideration, it is concluded that increased imports of articles like or directly competitive with the subject vehicles produced at the St. Louis #1 plant of Chrysler Corporation in Fenton, Missouri contributed importantly to the decline in sales or production and to the total or partial separation of workers at the St. Louis #1 plant of Chrysler Corporation in Fenton, Missouri. In accordance with the provisions of the Trade Act of 1974, I make the following revised determination:

All workers of the St. Louis #1 plant of Chrysler Corporation, Fenton, Missouri who became totally or partially separated from employment on or after January 24, 1989 are eligible to apply for adjustment assistance under Section 223 of the Trade Act of 1974.

Signed at Washington, DC, this 15th day of November 1991.

Stephen A. Wandner,

Deputy Director, Office of Legislation & Actuarial Services, Unemployment Insurance Service.

[FR Doc. 91-28211 Filed 11-22-91; 8:45 am]

BILLING CODE 4510-30-M

[TA-W-26,408]

General Automotive Specialty, North Brunswick, NJ; Termination of Investigation

Pursuant to Section 221 of the Trade Act of 1974, an investigation was initiated on October 7, 1991 in response to a worker petition which was filed on October 7, 1991 on behalf of workers at General Automotive Specialty, North Brunswick, New Jersey.

An active certification covering the petitioning group of workers remains in effect (TA-W-23,551—impact date of October 14, 1989 and an expiration date of December 5, 1991). Consequently, further investigation in this case would serve no purpose, and the investigation has been terminated.

Signed at Washington, DC, this 15th day of November.

Marvin M. Fooks,

Director, Office of Trade Adjustment Assistance.

[FR Doc. 91-28213 Filed 11-22-91; 8:45 am]

BILLING CODE 4510-30-M

Pension and Welfare Benefits Administration

[Prohibited Transaction Exemption 91-38]

Class Exemption for Certain Transactions Involving Bank Collective Investment Funds

AGENCY: Pension and Welfare Benefits Administration, Labor.

ACTION: Correction.

SUMMARY: In 56 FR published at page 31966 on Friday, July 12, 1991, make the following corrections:

On page 31969, in the third column in section IV(f), delete "(v)" and insert therein "(iii)"; and delete "(E)" and insert "(C)" therein.

Signed at Washington, DC this 20th day of November, 1991.

Ivan L. Strasfeld,

Director of Exemption Determinations, Pension and Welfare Benefits Administration, U.S. Department of Labor.

[FR Doc. 91-28279 Filed 11-22-91; 8:45 am]

BILLING CODE 4510-29-M

[Application No. D-8832]**Proposed Exemptions; Richard Edward Gruskin Keogh Plan**

AGENCY: Pension and Welfare Benefits Administration, Labor.

ACTION: Notice of proposed exemptions.

SUMMARY: This document contains notices of pendency before the Department of Labor (the Department) of proposed exemptions from certain of the prohibited transaction restriction of the Employee Retirement Income Security Act of 1974 (the Act) and/or the Internal Revenue Code of 1986 (the Code).

Written Comments and Hearing Requests

All interested persons are invited to submit written comments or request for a hearing on the pending exemptions, unless otherwise stated in the Notice of Proposed Exemption, within 45 days from the date of publication of this Federal Register Notice. Comments and request for a hearing should state: (1) The name, address, and telephone number of the person making the comment or request, and (2) the nature of the person's interest in the exemption and the manner in which the person would be adversely affected by the exemption. A request for a hearing must also state the issues to be addressed and include a general description of the evidence to be presented at the hearing. A request for a hearing must also state the issues to be addressed and include a general description of the evidence to be presented at the hearing.

ADDRESSES: All written comments and request for a hearing (at least three copies) should be sent to the Pension and Welfare Benefits Administration, Office of Exemption Determinations, room N-5649, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210. Attention: Application No. stated in each Notice of Proposed Exemption. The applications for exemption and the comments received will be available for public inspection in the Public Documents Room of Pension and Welfare Benefits Administration, U.S. Department of Labor, room N-5507, 200 Constitution Avenue, NW., Washington, DC 20210.

Notice to Interested Persons

Notice of the proposed exemptions will be provided to all interested persons in the manner agreed upon by the applicant and the Department within 15 days of the date of publication in the Federal Register. Such notice shall include a copy of the notice of proposed

exemption as published in the Federal Register and shall inform interested persons of their right to comment and to request a hearing (where appropriate).

SUPPLEMENTARY INFORMATION: The proposed exemptions were requested in applications filed pursuant to section 408(a) of the Act and/or section 4975(c)(2) of the Code, and in accordance with procedures set forth in 29 CFR part 2570, subpart B (55 FR 32836, 32847, August 10, 1990). Effective December 31, 1978, section 102 of Reorganization Plan No. 4 of 1978 (43 FR 47713, October 17, 1978) transferred the authority of the Secretary of the Treasury to issue exemptions of the type requested to the Secretary of Labor. Therefore, these notices of proposed exemption are issued solely by the Department.

The applications contain representations with regard to the proposed exemptions which are summarized below. Interested persons are referred to the applications on file with the Department for a complete statement of the facts and representations.

Richard Edward Gruskin Keogh Plan (the Plan) Located in New London, Connecticut

[Exemption Application No. D-8832]

Proposed Exemption

The Department is considering granting an exemption under the authority of section 4975(c)(2) of the Code and in accordance with the procedures set forth in 29 CFR part 2570, subpart B (55 FR 32836, 32847, August 10, 1990). If the exemption is granted the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1) (A) through (E) of the Code, shall not apply to the proposed loan of \$50,000 (the Loan) by the Plan to Richard E. Gruskin¹ (Mr. Gruskin), a disqualified person with respect to the Plan, provided that the following conditions are satisfied:

(A) On the day the transaction is entered into, the Loan will be secured by a first mortgage on certain real property (the Property), which has been appraised by a qualified independent appraiser to assure that the net fair market value of the Property is at least 150% of the amount of the Loan;²

¹ Because Mr. Gruskin is the only participant in the Plan and the Employer is wholly owned by Mr. Gruskin there is no jurisdiction under Title I of the Act pursuant to 29 CFR 2510.3-3(b). However, there is jurisdiction under title II of the Act pursuant to section 4975 of the Code.

² Net fair market value in this case refers to fair market value after all and any taxes, liens,

(B) The net fair market value of the collateral will remain at least 150% of the Loan to collateral value ratio for the duration of the Loan;

(C) On the date the transaction is entered into, the interest rate on the Loan will be determined by reference to the interest rate that an independent bank or similar financial institution would charge on a comparable loan of similar duration and risk;

(D) On the date the transaction is entered into, the promissory note (the Note) which will evidence the Loan, will reflect the current interest rate and repayment schedule and will include a provision that if the Property is sold to an independent third party at any time during the term of the Loan, the outstanding principal balance plus any accrued, but unpaid interest on the Loan will become immediately due and payable;

(E) The Loan will at no time exceed 25% of the Plan's total assets, and the Plan will incur no expenses with respect to the transaction; and

(F) Mr. Tedeschi, the independent trustee of the Plan, will be responsible for monitoring the Loan repayment and enforcing the rights of the Plan with respect to the Loan.

Summary of Facts and Representations

1. The Plan is a Keogh plan, of which Mr. Gruskin is the sole participant. As of December 31, 1990, the Plan had approximately \$362,404 in total assets. The trustee of the Plan is John P. Tedeschi (Mr. Tedeschi), an attorney located in New London, Connecticut, who is independent of Mr. Gruskin. The proposed transaction involves approximately 14% of the Plan's total assets. Mr. Gruskin is an attorney in the State of Connecticut with the law firm of Gruskin and Gruskin (the Employer), a sole proprietorship, which is the sponsor of the Plan. Mr. Gruskin proposes to borrow \$50,000 from the Plan.

2. The Loan will have a fixed interest rate of 11% and will be payable in equal monthly payments of principal and interest until the Loan is fully paid off by July, 1996. The Note which will evidence the Loan will provide for no penalty in the event of full or partial prepayment. On the date the transaction is entered into, the Note will reflect the current interest rate and repayment schedule on the Loan.

3. Mr. Tedeschi has represented that he will serve as independent fiduciary with respect to the Plan for the proposed transaction and will be responsible for

easements and any other encumbrances on the Property have been accounted for.

monitoring the Loan repayment and enforcing the Plan's rights with respect to the Loan. On the date the transaction is entered into, the Loan will be secured by a first mortgage on the Property located in Waterford, Connecticut, which was appraised by F. Jerome Silverstein, MAI, SRPA (Mr. Silverstein), an independent qualified appraiser. Mr. Silverstein represents that the Property is a "U" shaped parcel of land with a frontage of 268 feet on Waterford Parkway North plus additional frontage of 161 feet. There is also frontage of 425 feet on Cross Road. The Property is 12 to 15 feet below grade at the intersection of Cross Road and Waterford Parkway North. About 4 acres are swamp and 9.06 acres are wooded. The Property is in the Industrial-Commercial Zone.

4. Mr. Silverstein used the comparable sales appraisal method and concluded that as of September 4, 1991, the fair market value of the Property was \$473,000, which is based on a value of \$50,000 an acre for the usable land ($9.06 \times 50,000$) and a nominal value of \$5,000 an acre for the wetlands ($4 \times \$5,000$). Mr. Gruskin represents that there is a water and sewer tax lien on the Property for \$7,058 which was due December 1, 1989, which Mr. Gruskin is contesting.

5. The applicant desires to enter into the loan transaction because he represents that the transaction is administratively feasible, protective and in the best interest of the Plan. The Plan will bear no expenses with respect to the proposed transaction and the Loan will involve approximately 14% of the Plan's total assets. By letter dated March 19, 1991, the New England Savings Bank which is located in New London, Connecticut, stated that it would consider entering into a similar loan with Mr. Gruskin at an interest rate of 11%. Also, the collateral has been appraised by an independent qualified appraiser.

6. In summary, the applicant represents that the transaction satisfies the statutory criteria of section 4975(c)(2) of the Code because:

(A) On the date the transaction is entered into, the Loan will be secured by the Property;

(B) The net fair market value of the collateral will remain at least 150% of the Loan to collateral value ratio for the duration of the Loan;

(C) The Loan will at no time exceed 25% of the Plan's total assets;

(D) The Plan will incur no expenses with respect to the transaction;

(E) The fair market value of the Land was determined by an independent, qualified appraiser;

(F) The interest rate on the Loan will be determined by reference to the interest rate an independent bank or a similar financial institution would charge on a comparable loan of similar duration and risk; and

(G) Mr. Gruskin is the sole participant of the Plan and he desires that the transaction be consummated.

Notice To Interested Persons

Because Mr. Gruskin is the only person to be affected by the proposed transaction, it has been determined that it is not necessary to distribute this notice of proposed exemption to interested persons. Comments and requests for a hearing are due 30 days from the date of publication of this notice in the Federal Register.

FOR FURTHER INFORMATION CONTACT: Ekaterina A. Uzlyan of the Department, telephone (202) 523-8883. (This is not a toll-free number.)

General Information

The attention of interested persons is directed to the following:

(1) The fact that a transaction is the subject of an exemption under section 408(a) of the Act and/or section 4975(c)(2) of the Code does not relieve a fiduciary or other party in interest of disqualified person from certain other provisions of the Act and/or the Code, including any prohibited transaction provisions to which the exemption does not apply and the general fiduciary responsibility provisions of section 404 of the Act, which among other things require a fiduciary to discharge his duties respecting the plan solely in the interest of the participants and beneficiaries of the plan and in a prudent fashion in accordance with section 404(a)(1)(b) of the act; nor does it affect the requirement of section 401(a) of the Code that the plan must operate for the exclusive benefit of the employees of the employer maintaining the plan and their beneficiaries;

(2) Before an exemption may be granted under section 408(a) of the Act and/or section 4975(c)(2) of the Code, the Department must find that the exemption is administratively feasible, in the interests of the plan and of its participants and beneficiaries and protective of the rights of participants and beneficiaries of the plan; and

(3) The proposed exemptions, if granted, will be supplemental to, and not in derogation of, any other provisions of the Act and/or the Code, including statutory or administrative exemptions and transitional rules. Furthermore, the fact that a transaction is subject to an administrative or statutory exemption is not dispositive of

whether the transaction is in fact a prohibited transaction.

(4) The proposed exemptions, if granted, will be subject to the express condition that the material facts and representations contained in each application are true and complete, and that each application accurately describes all material terms of the transaction which is the subject of the exemption.

Signed at Washington, DC, this 20th day of November, 1991.

Ivan Strasfeld,

*Director of Exemption Determinations,
Pension and Welfare Benefits Administration,
U.S. Department of Labor.*

[FR Doc. 91-28280 Filed 11-22-91; 8:45 am]

BILLING CODE 4510-29-M

NATIONAL FOUNDATION ON THE ARTS AND THE HUMANITIES

Advisory Panel of the Folk Arts

Pursuant to section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92-463), as amended, notice is hereby given that a meeting of the Folk Arts Advisory Panel (Organizations; State Arts Apprenticeships; Advancement Section) to the National Council on the Arts will be held on December 10-12, 1991, from 9 a.m.-6 p.m. and December 13 from 9 a.m.-5 p.m. in room 716 at the Nancy Hanks Center, 1100 Pennsylvania Avenue, NW., Washington, DC 20506.

A portion of this meeting will be open to the public on December 12 from 1 p.m.-2:30 p.m. The topic will be policy discussion.

The remaining portions of this meeting on December 10-11 from 9 a.m.-6 p.m., December 12 from 9 a.m.-1 p.m. and 2:30 p.m.-6 p.m., and December 13 from 9 a.m. to 5 p.m. are for the purpose of Panel review, discussion, evaluation, and recommendation on applications for financial assistance under the National Foundation on the Arts and the Humanities Act of 1965, as amended, including information given in confidence to the agency by grant applicants. In accordance with the determination of the Chairman of September 23, 1991, as amended, these sessions will be closed to the public pursuant to subsection (c)(4), (6) and (9)(B) of section 552b of title 5, United States Code.

Any person may observe meetings, or portions thereof, of advisory panels which are open to the public, and may be permitted to participate in the panel's discussions at the discretion of the panel chairman and with the approval of the

full-time Federal employee in attendance.

If you need special accommodations due to a disability, please contact the Office of Special Constituencies, National Endowment for the Arts, 1100 Pennsylvania Avenue, NW., Washington, DC 20506, 202/682-5532, TTY 202/682-5496, at least seven (7) days prior to the meeting.

Further information with reference to this meeting can be obtained from Ms. Yvonne M. Sabine, Advisory Committee Management Officer, National Endowment for the Arts, Washington, DC 20506, or call (202) 682-5433.

Dated: November 12, 1991.

Yvonne M. Sabine,

Director, Council and Panel Operations,
National Endowment for the Arts.

[FR Doc. 91-28229 Filed 11-22-91; 8:45 am]

BILLING CODE 7537-01-M

NATIONAL SCIENCE FOUNDATION

Permit Issued Under the Antarctic Conservation Act of 1978

AGENCY: National Science Foundation.

ACTION: Notice of permit issued under the Antarctic Conservation Act of 1978, Public Law 95-541.

SUMMARY: The National Science Foundation (NSF) is required to publish notice of permits issued under the Antarctic Conservation Act of 1978. This is the required notice of permits issued.

FOR FURTHER INFORMATION CONTACT: Charles E. Myers, Permit Office, Division of Polar Programs, National Science Foundation, Washington, DC 20550.

SUPPLEMENTARY INFORMATION: On October 10, 1991, the National Science Foundation published a notice in the Federal Register of permit applications received. A permit was issued to Arthur L. DeVries on November 15, 1991.

Charles E. Myers,

Permit Office, Division of Polar Programs.

[FR Doc. 91-28209 Filed 11-22-91; 8:45 am]

BILLING CODE 7555-01-M

Advisory Committee for Mathematical Sciences; Meeting

In accordance with the Federal Advisory Committee Act, Public Law 92-463, as amended, the National Science Foundation announces the following meeting:

Name: Advisory Committee for Mathematical Sciences.

Date & Time: December 12-13, 1991—8:30 a.m. to 5 p.m. each day, December 14, 1991—8:30 a.m. to 12 noon.

Place: Room 540, National Science Foundation, 1800 G Street, NW., Washington, DC 20550.

Type of Meeting: Part Open—(Thursday, December 12, 8:30 a.m. through 10:30 a.m.; and Friday, December 13, 10 a.m. to close of meeting). Part Closed—(Thursday, December 12, 10:30 a.m. to Friday, December 13, 10 a.m.).

Contact Person: Dr. Judith S. Sunley, Division Director, Division of Mathematical Sciences, room 339, National Science Foundation, Washington, DC 20550.

Telephone (202) 357-9669. Electronic mail: jsunley@nsf.gov. Anyone planning to attend this meeting should notify Dr. Sunley no later than December 9, 1991.

Purpose of Committee: To provide advice and recommendations concerning support for research in the mathematical sciences. To carry out Committee of Visitors review of the Classical Analysis, Modern Analysis, Statistics and Probability, and Topology and Foundations programs.

Agenda:

Thursday, December 12, 1991 8:30 a.m. to 10:30 a.m.—Open

Introductory Remarks

Overview of FY 1991

Preview of FY 1992

Charge to Committees of Visitors

Thursday, December 12, 1991, 10:30 a.m. to Friday, December 13, 1991, 10 a.m.—Closed

Committee of Visitors Review of Classical Analysis, Modern Analysis, Statistics and Probability, and Topology and Foundations; including examination of proposals, reviewer comments, and other privileged materials.

Friday, December 13, 1991 after 10 a.m. and

Saturday, December 14, 1991 to 12 noon—Open

Report of the Committees of Visitors

Classical Analysis

Modern Analysis

Statistics and Probability

Topology and Foundations

Discussion of COV Reports

Progress on Advisory Committee

Recommendations

Activities of the Mathematical Sciences

Community

Priorities for the Mathematical Sciences

Plans and assignments for Spring, 1992,

meeting

Other business

Reason for Closing: The Committees of Visitor's review of proposal actions will include privileged intellectual property and personal information that could harm individuals if it were disclosed. If discussions were open to the public, these matters that are exempt under 5 U.S.C. 552(b)(4) and (6) of the Government in the Sunshine Act would be improperly disclosed.

Dated: November 20, 1991.

M. Rebecca Winkler,

Committee Management Officer.

[FR Doc. 91-28244 Filed 11-22-91; 8:45 am]

BILLING CODE 7555-01-M

NUCLEAR REGULATORY COMMISSION

Advisory Committee on Reactor Safeguards, Subcommittee on Improved Light Water Reactors; Meeting

The Subcommittee on Improved Light Water Reactors will hold a meeting on December 11, 1991, room P-110, 7920 Norfolk Avenue, Bethesda, MD.

The entire meeting will be open to public attendance.

The agenda for the subject meeting shall be as follows: Wednesday December 11, 1991—8:30 a.m. until the conclusion of business.

The Subcommittee will review draft safety evaluation reports of the EPRI's Requirements Document for Evolutionary Designs and recommended course of action on adhering to 10 CFR part 52.

Oral statements may be presented by members of the public with the concurrence of the Subcommittee Chairman; written statements will be accepted and made available to the Committee. Recordings will be permitted only during those sessions of the meeting when a transcript is being kept, and questions may be asked only by members of the Subcommittee, its consultants, and staff. Persons desiring to make oral statements should notify the ACRS staff member named below as far in advance as is practicable so that appropriate arrangements can be made.

During the initial portion of the meeting, the Subcommittee, along with any of its consultants who may be present, may exchange preliminary views regarding matters to be considered during the balance of the meeting.

The Subcommittee will hear presentations by and hold discussions with representatives of the NRC staff, their consultants, and other interested persons regarding this review.

Further information regarding topics to be discussed, the scheduling of sessions open to the public, whether the meeting has been cancelled or rescheduled, the Chairman's ruling on requests for the opportunity to present oral statements and the time allotted therefor can be obtained by a prepaid telephone call to the cognizant ACRS staff member, Mr. Medhat El-Zeftawy (telephone 301/492-9901) between 7:30 a.m. and 4:15 p.m. Persons planning to attend this meeting are urged to contact the above named individual one or two days before the scheduled meeting to be advised of any changes in schedule, etc., that may have occurred.

Dated: November 18, 1991.
 Gary R. Quittschreiber,
Chief, Nuclear Reactors Branch.
 [FR Doc. 91-28223 Filed 11-22-91; 8:45 am]
 BILLING CODE 7590-01-M

**Advisory Committee on Reactor
 Safeguards, Subcommittee on Safety
 Philosophy, Technology and Criteria;
 Meeting**

The Subcommittee on Safety Philosophy, Technology and Criteria will hold a meeting on December 5, 1991, Room P-110, 7920 Norfolk Avenue, Bethesda, MD.

The entire meeting will be open to public attendance.

The agenda for the subject meeting shall be as follows: Thursday, December 5, 1991—8:30 a.m. until 12 noon.

The Subcommittee will discuss SECY-91-270, "Interim Guidance on Staff Implementation of the Commission's Safety Goal Policy," and SECY-91-262, "Resolution of Selected Technical and Severe Accident Issues for Evolutionary Light Water Reactor (LWR) Designs."

Oral statements may be presented by members of the public with the concurrence of the Subcommittee Chairman; written statements will be accepted and made available to the Committee. Recordings will be permitted only during those sessions of the meeting when a transcript is being kept, and questions may be asked only by members of the Subcommittee, its consultants, and staff. Persons desiring to make oral statements should notify the ACRS staff member named below as far in advance as is practicable so that appropriate arrangements can be made.

During the initial portion of the meeting, the Subcommittee, along with any of its consultants who may be present, may exchange preliminary views regarding matters to be considered during the balance of the meeting.

The Subcommittee will hear presentations by and hold discussions with representatives of the NRC staff, their consultants, and other interested persons regarding this review.

Further information regarding topics to be discussed, the scheduling of sessions open to the public, whether the meeting has been cancelled or rescheduled, the Chairman's ruling on requests for the opportunity to present oral statements and the time allotted therefor can be obtained by a prepaid telephone call to the cognizant ACRS staff member, Mr. Dean Houston (telephone 301/492-9521) between 7:30 a.m. and 4:15 p.m. Persons planning to attend this meeting are urged to contact

the above named individual one or two days before the scheduled meeting to be advised of any changes in schedule, etc., that may have occurred.

Dated: November 8, 1991.
 Gary R. Quittschreiber,
Chief, Nuclear Reactors Branch.
 [FR Doc. 91-28224 Filed 11-22-91; 8:45 am]
 BILLING CODE 7590-01-M

**Event Reporting Systems (10 CFR
 50.72 and 50.73): Clarification of NRC
 Systems and Guidelines for Reporting
 Availability of Draft Report: Extension
 of Comment Period**

AGENCY: Nuclear Regulatory Commission.

ACTION: Notice of availability: Extension of comment period.

SUMMARY: On October 7, 1991, (56 FR 50598), the Nuclear Regulatory Commission (NRC) announced the availability for public comment of draft report, NUREG-1022, Revision 1, "Event Reporting Systems—10 CFR 50.72 and 50.73: Clarification of NRC Systems and Guidelines for Reporting." The comment period for this report was to have expired on December 6, 1991. The Nuclear Management and Resources Council (NUMARC) has requested an extension of the comment period to the end of January 1992. In view of the importance of the proposed NUREG and the amount of time that the NUMARC suggests is required to provide meaningful comments on behalf of its member utilities, the NRC has decided to extend the comment period to January 31, 1992.

DATES: The comment period has been extended and now expires on January 31, 1992. Comments received after this date will be considered if it is practical to do so, but the Commission is able to assure consideration only for comments received before this date.

ADDRESSES: Send written comments or suggestions to David L. Meyer, Chief, Regulatory Publications Branch, Division of Freedom of Information and Publication Services, Office of Administration, U.S. Nuclear Regulatory Commission, Washington, DC 20555. Copies of comments received may be examined at the NRC Public Document Room, 2120 L Street, NW. (Lower Level), Washington, DC 20555.

FOR FURTHER INFORMATION CONTACT: John L. Crooks, Chief, Data Management Section, Trends and Patterns Analysis Branch, Division of Safety Programs, Office for Analysis and Evaluation of Operational Data, U.S. Nuclear Regulatory Commission, Mail Stop

MNBB 9112, Washington, DC 20555.
 Telephone 301/492-4425.

Dated at Bethesda, Maryland, this 19th day of November, 1991.

For the Nuclear Regulatory Commission.
 Patrick W. Baranowsky,
*Acting Director, Division of Safety Programs,
 Office for Analysis and Evaluation of
 Operational Data.*
 [FR Doc. 91-28220 Filed 11-22-91; 8:45 am]
 BILLING CODE 7590-01-M

[Docket No. 50-341]

**Detroit Edison Co.; FERMI-2, Issuance
 of Amendment To Facility Operating
 License**

The U.S. Nuclear Regulatory Commission (Commission) has issued Amendment No. 76 to Facility Operating License No. NPF-43 issued to Detroit Edison Company, which revised the Technical Specifications for operation of Fermi-2, located in Monroe County, Michigan.

The amendment is effective as of the date of issuance.

The amendment revised the Technical Specification (TS) allowing routine surveillance testing of the Reactor Water Cleanup System (RWCS) without necessitating removal of the RWCS from service.

The application for the amendment complies with the standards and requirements of the Atomic Energy Act of 1954, as amended (the Act), and the Commission's rules and regulations. The Commission has made appropriate findings as required by the Act and the Commission's rules and regulations in 10 CFR chapter I, which are set forth in the license amendment.

Notice of Consideration of Issuance of Amendment and Opportunity for Hearing in connection with this action was published in the *Federal Register* on June 20, 1989 (54 FR 26866). No request for a hearing or petition for leave to intervene was filed following this notice.

The Commission has prepared an Environmental Assessment related to the action and has determined not to prepare an environmental impact statement. Based upon the environmental assessment, the Commission has concluded that the issuance of this amendment will not have a significant effect on the quality of the human environment.

For further details with respect to the action see (1) the application for amendment dated December 22, 1988, (2) Amendment No. 76- to License No. NPF-43, and (3) the Commission's related Safety Evaluation and

Environmental Assessment. All of these items are available for public inspection at the Commission's Public Document Room, 1717 H Street NW., and at the Monroe County Library System 3700 South Luster Road, Monroe, Michigan 48161. A copy of items (2) and (3) may be obtained upon request addressed to the U.S. Nuclear Regulatory Commission, Washington, DC 20555, Attention: Director, Division of Reactor Projects III/IV/V.

Dated at Rockville, Maryland this 19th day of November 1991.

For the Nuclear Regulatory Commission.

John F. Stang, Sr.,

Project Manager, Project Directorate III-1,
Division of Reactor Projects—III/IV/V,
Office of Nuclear Reactor Regulation.

[FR Doc. 91-28219 Filed 11-22-91; 8:45 am]

BILLING CODE 7590-01-M

Advisory Committee on Reactor Safeguards (ACRS) and Advisory Committee on Nuclear Waste (ACNW); Proposed Meetings

In order to provide advance information regarding proposed public meetings of the ACRS Subcommittees and meetings of the ACNW full Committee, of the ACNW, and the ACNW Working Groups the following preliminary schedule is published to reflect the current situation, taking into account additional meetings which have been scheduled and meetings which have been postponed or canceled since the last list of proposed meetings was published October 25, 1991 (56 FR 55354). Those meetings which are definitely scheduled have had, or will have, an individual notice published in the *Federal Register* approximately 15 days (or more) prior to the meeting. It is expected that sessions of ACRS full Committee and ACNW meetings designated by an asterisk (*) will be closed in whole or in part to the public. ACRS full Committee and ACNW meetings begin at 8:30 a.m. and ACRS Subcommittee and ACNW Working Group meetings usually begin at 8:30 a.m. The time when items listed on the agenda will be discussed during ACRS full Committee and ACNW meetings, and when ACRS Subcommittee and ACNW Working Group meetings will start will be published prior to each meeting. Information as to whether a meeting has been firmly scheduled, cancelled, or rescheduled, or whether changes have been made in the agenda for the December 1991 ACRS and ACNW full Committee meetings can be obtained by a prepaid telephone call to the Office of the Executive Director of the Committees (telephone: 301/492-

4600 (recording) or 301/492-7288, Attn: Barbara Jo White) between 7:30 a.m. and 4:15 p.m., eastern time.

ACRS Subcommittee Meetings

Joint Computers in Nuclear Power Plant Operations/Advanced Pressurized Water Reactors, December 3-4, 1991, Bethesda, MD. The Subcommittees will hear presentations by Westinghouse and ABB Combustion Engineering regarding their digital computer experiences in nuclear power plants.

Regional Programs, December 5, 1991, NRC Region V Office, Walnut Creek, CA—Postponed.

Safety Philosophy, Technology and Criteria, December 5, 1991, Bethesda, MD. The Subcommittee will discuss SECY-91-270, "Interim Guidance on Staff Implementation of the Commissions Safety Goal Policy," and SECY-91-262, "Resolution of Selected Technical and Severe Accident Issues for Evolutionary Light Water Reactor (LWR) Designs."

Extreme External Phenomena, December 10, 1991, Bethesda, MD. The Subcommittee will discuss the proposed revisions to 10 CFR part 100, appendix A, "Seismic and Geologic Siting Criteria for Nuclear Power Plants."

Improved Light Water Reactors, December 11, 1991, Bethesda, MD. The Subcommittee will review draft safety evaluation reports pertaining to the EPRI's Requirements Document for the Evolutionary Designs and recommended course of action on adhering to 10 CFR part 52.

Reliability Assurance, December 10, 1991, Bethesda, MD, 1 p.m.—Postponed.

Joint Safety Philosophy, Technology and Criteria/Severe Accidents/Regulatory Policies and Practices, January 7-8, 1992, Bethesda, MD. The Subcommittees will discuss a number of interrelated proposed NRC staff position papers as follows: (1) Proposed Definition of a Large Release for Safety Goal Policy Implementation, (2) Proposed Revision to TID-14844 to Update Source Term, (3) Proposed Revision to 10 CFR part 100, Decoupling Siting from Design, and (4) Site Characteristics to be Used in Part 100 Revision and Large Release Determination.

Safety Research Program, January 14, 1992, Bethesda, MD. The Subcommittee will hold a round-table discussion on the scope, nature and approach of a proposed Committee report on the NRC-RES safety research program.

Auxiliary and Secondary Systems, January 22, 1992 (tentative), 1 p.m., Bethesda, MD. The Subcommittee will discuss the proposed resolution of Generic Issue 106, "Piping and Use of

Highly Combustible Gases in Vital Areas."

Advanced Boiling Water Reactors, January 23-24, 1992, Bethesda, MD. The Subcommittee will review SECY-91-294 and SECY-91-309, addressing two Draft Safety Evaluation Reports (DSERs) related to different chapters of the GE/Standard Safety Analysis Report (SSAR) for the ABWR design, and other related issues.

Joint Mechanical Components/Auxiliary and Secondary Systems, February 19, 1992, Bethesda, MD (tentative). The Subcommittees will review the status of the industry check valve and motor-operated valve (MOV) operability programs, and the status of Generic Issue-57, "Effects of Fire Protection System Actuation of Safety Related Equipment."

Advanced Boiling Water Reactors, February 20-21, 1992, Bethesda, MD. The Subcommittee will review SECY-91-320 and SECY-91-355, addressing two DSERs related to different chapters of the GE/SSAR for the ABWR design, and other related issues.

Joint Plant Operations/Probabilistic Risk Assessment, Date to be determined (December/January), Bethesda, MD. The Subcommittees will continue the review of the NRC staff's program to address the issue of risk from low power/shutdown operations of nuclear power plants.

Thermal Hydraulic Phenomena, Date to be determined (late January), Bethesda, MD. The Subcommittee will review the NRC staff's SECY Paper describing plans for development of proposed test facilities to address safety issues pertaining to the thermal hydraulic design parameters for the Westinghouse AP-600 passive nuclear plant design.

Advanced Reactor Designs, Date and location to be determined (January). The Subcommittee will visit the ORNL facility and will discuss the testing program and experiments for the MHTGR design.

Joint Individual Plant Examinations/Severe Accidents, Date to be determined (January/February), Bethesda, MD. The Subcommittee will discuss the status of the IPE program and the development of Severe Accident Management Guidelines.

Advanced Pressurized Water Reactors, Date to be determined (February), Bethesda, MD. The Subcommittee will continue its review of the ABB CE System 80+ CESSAR for Design Certification. Subject material being proposed for discussion includes consideration of safeguard systems and USIs/GSIs.

Thermal Hydraulic Phenomena, Date to be determined (Winter, tentative), Bethesda, MD. The Subcommittee will continue its review of the NRC staff program to address the issue of interfacing systems LOCAs.

Joint Thermal Hydraulic Phenomena/Core Performance, Date to be determined (April, tentative) Bethesda, MD. The Subcommittee will continue the review of the issues pertaining to BWR core power stability.

Reliability Assurance, Date and location to be determined, Bethesda, MD. The Subcommittee will discuss with the NRC staff and the industry, research and other matters regarding nuclear power plant aging phenomena.

Regional Programs, Date to be determined, NRC Region V Office, Walnut Creek, CA. The Subcommittee will discuss the activities of the NRC Region V Office.

Thermal Hydraulic Phenomena, Date to be determined, Bethesda, MD. The Subcommittee will review the status of the application of the Code Scaling, Applicability, and Uncertainty (CSAU) Evaluation Methodology to a small-break LOCA calculation for a B&W plant.

Thermal Hydraulic Phenomena, Date to be determined, Los Alamos, NM. The Subcommittee will review the documentation associated with the TRAC-PF1/MOD2 code version.

Structural Engineering, Date to be determined, Bethesda, MD. The Subcommittee will discuss with the NRC staff and the industry the status of Containment Structural Integrity programs, including foreign programs.

Joint Materials and Metallurgy/Maintenance Practice and Procedures, Date to be determined, Bethesda, MD. The Subcommittees will discuss Risk-Based Inspection Guidelines.

ACRS Full Committee Meetings

380th ACRS Meeting, December 12-14, 1991, Bethesda, MD. Items are tentatively scheduled.

A. Diesel Generator Reliability—Review and report on proposed amendment to the NRC Station Blackout rule regarding resolution of Generic Issue B-56, "Diesel Generator Reliability." Representatives of the NRC staff and the nuclear industry will participate, as appropriate.

B. Key Technical Issues for Future Nuclear Power Plant Designs (tentative)—Discussion of action plans for proposed resolution of a selected set of key technical issues for future nuclear power plant designs that are in need of early resolution.

C. Resolution of Selected Technical and Severe Accident Issues for

Evolutionary Light Water Reactor (LWR) Designs (SECY-91-262)—Review and report on the matters discussed in SECY-91-262. Representatives of the NRC staff and the nuclear industry will participate, as appropriate.

D. Interim Guidance on Staff Implementation of the Commission's Safety Goal Policy (SECY-91-270)—Review and report on the matters discussed in this SECY paper. Representatives of the NRC staff and the nuclear industry will participate, as appropriate.

E. Role of Personnel and Advanced Control Rooms in Future Nuclear Power Plants (SECY-91-272)—Review and report on the matters discussed in this SECY paper. Representatives of the NRC staff and the nuclear industry will participate, as appropriate.

F. Standard Technical Specifications—Briefing by representatives of the NRC staff regarding the status of the program to develop standard technical specifications for nuclear power plants.

G. Design Acceptance Criteria for Certification of Standardized Nuclear Power Plants—Briefing/review and report as appropriate on the NRC staff evaluation of the use of Design Acceptance Criteria in the certification and combined licenses for standardized nuclear power plants per 10 CFR part 52, Early Site Permits; Standard Design Certifications; and Combined Licenses for Nuclear Power Plants.

H. Meeting with NRC Commissioners—Discussion of items of mutual interest including the status of proposed ACRS action regarding key technical issues for future nuclear power plants.

I. ACRS Subcommittee Activities (Open/Closed)—Reports and discussions regarding the status of designated subcommittee activities including: review of proposed best estimate ECCS evaluation models for 3- and 4-loop Westinghouse plants, Westinghouse and Combustion Engineering experience with the use of digital computers in nuclear power plants, and a report by the ACRS Ad-Hoc Subcommittee on Key Technical Issues. Portions of these sessions may be closed to discuss Proprietary Information related to these matters.

J. Resolution of ACRS Comments/Recommendations—Discussion of proposed NRC resolution of the ACRS comments and recommendations made in recent Committee reports regarding reactor safety matters including proposed implementation of the results of the NRC regulatory impact survey and the consistent use of probabilistic risk assessment in the regulatory

process. Representatives of the NRC staff will participate, as appropriate.

K. Future Committee Activities—Discuss anticipated subcommittee activities and items proposed for consideration by the full Committee.

L. Administrative Matters (Open/Closed)—Election of Committee officers for CY 1992. A discussion of administrative matters related to the nomination and selection of new Committee members. Portions of this session will be closed as necessary to discuss information the release of which would represent a clearly unwarranted invasion of personal privacy.

M. Organizational Factors Research—Briefing by and discussion with representatives of the NRC staff regarding the status of the NRC staff's research programs on organizational factors.

N. Control of Nuclear Power Plant Switchyard Activities (tentative)—Discussion of proposed ACRS actions/comments regarding the impact of licensee control of switchyard activities on the initiation and/or course of nuclear power plant transients and incidents.

O. Miscellaneous—Discuss matters and specific issues that were not completed during previous meetings as time and availability of information permit.

318th ACRS Meeting, January 9-11, 1992, Bethesda, MD—Agenda to be announced.

382nd ACRS Meeting, February 6-8, 1992, Bethesda, MD—Agenda to be announced.

ACNW Full Committee and Working Group Meetings

ACNW Working Group on Concerns Related to Seismic and Faulting Investigations for Characterization of an HLW Site, December 17, 1991, Bethesda, MD. The Working Group will hear the current thinking by DOE, the State of Nevada, American Society of Civil Engineers, and other interested parties regarding seismic and faulting investigations of a high-level waste site.

38th ACNW Meeting, December 18-19, 1991, Bethesda, MD. Items are tentatively scheduled.

A. Review the Staff Technical Position on the Identification of Fault Displacement and Seismic Hazards at a Geologic Repository.

B. Discuss the results of a Working Group meeting on concerns related to Faulting and Seismic Investigations of a proposed HLW repository site.

C. Discuss items of mutual interest with the Commission.

D. Election of Committee officers for CY 1992 (Closed). This session will be

closed as necessary to discuss information the release of which would represent a clearly unwarranted invasion of personal privacy.

E. Consider revision to NUREG-1200, Standard Review Plan for LLW Facility.

F. Consider revisions to 10 CFR part 61.

G. Comment on a number of issues in the field of low-level waste disposal including: steps to decrease low-level radioactive waste production, reporting mishaps in handling the management of low-level wastes and protection of groundwater from low-level radioactive waste effluents.

H. Develop a response to Chairman Selin on a systems analysis approach to the storage of spent fuel.

I. Prepare a program plan for the next four months.

J. Discuss anticipated and proposed Committee activities, future meeting agenda, administrative, and organizational matters, as appropriate. Also, discuss matters and specific issues that were not completed during previous meetings as time and availability of information permit.

ACNW Working Group on the Impact of Long-Range Climate Change in the Area of the Southern Basin and Range, January 15, 1992, Bethesda, MD. The Working Group will review potential long-range climate changes and their impact on performance assessments for a proposed high-level waste repository.

39th ACNW Meeting, January 16-17, 1992, Bethesda, MD—Agenda to be announced.

40th ACNW Meeting, February 20-21, 1992, Bethesda, MD—Agenda to be announced.

ACNW Working Group on Methods for Assessing Natural Resources at a Proposed High-Level Waste Repository Site, Date to be determined, Bethesda, MD. The Working Group will discuss methodologies for the assessment of the potential for natural resources at the proposed high-level waste repository site at Yucca Mountain. The relationship between such resources and the potential for human intrusion will be emphasized.

ACNW Working Group on Residual Contamination Clean-up Criteria, Date to be determined, Bethesda, MD. The Working Group will review, discuss and make recommendations regarding the clean-up criteria levels for unrestricted use of contaminated sites that are or have been under NRC/AEC license.

Dated: December 19, 1991.

John C. Hoyle,

Advisory Committee Management Officer.

[FR Doc. 91-28221 Filed 11-22-91; 8:45 am]

BILLING CODE 7590-01-M

Advisory Committee on Reactor Safeguards Subcommittee on Extreme External Phenomena; Meeting

The ACRS Subcommittee on Extreme External Phenomena will hold a meeting on December 10, 1991, room P-110, 7920 Norfolk Avenue, Bethesda, MD.

The entire meeting will be open to public attendance. The agenda for the subject meeting shall be as follows: Tuesday, December 10, 1991—8:30 a.m. until the conclusion of business.

The Subcommittee will discuss the proposed revisions to 10 CFR part 100, appendix A, "Seismic and Geologic Siting Criteria for Nuclear Power Plants."

Oral statements may be presented by members of the public with the concurrence of the Subcommittee Chairman; written statements will be accepted and made available to the Committee. Recordings will be permitted only during those sessions of the meeting when a transcript is being kept, and questions may be asked only by members of the Subcommittee, its consultants, and staff. Persons desiring to make oral statements should notify the ACRS staff member named below as far in advance as is practicable so that appropriate arrangements can be made.

During the meeting, the Subcommittee, along with any of their consultants who may be present, may exchange preliminary views regarding matters to be considered during the balance of the meeting.

The Subcommittee will hear presentations by and hold discussions with representatives of the NRC staff, the nuclear industry, their respective consultants, and other interested persons regarding this review.

Further information regarding topics to be discussed, the scheduling of sessions open to the public, whether the meeting has been cancelled or rescheduled, the Chairman's ruling on requests for the opportunity to present oral statements and the time allotted therefore can be obtained by a prepaid telephone call to the Designated Federal Official, Mr. Dean Houston (telephone 301/492-9521) between 7:30 a.m. and 4:15 p.m. Persons planning to attend this meeting are urged to contact the above named individual one or two days before the scheduled meeting to be advised of any changes in schedule, etc., that may have occurred.

Dated: November 18, 1991.

Gary R. Quittschreiber,

Chief, Nuclear Reactors Branch.

[FR Doc. 91-28222 Filed 11-22-91; 8:45 am]

BILLING CODE 7590-01-M

SECURITIES AND EXCHANGE COMMISSION

Self-Regulatory Organizations; Applications for Unlisted Trading Privileges and of Opportunity for Hearing; Cincinnati Stock Exchange, Inc.

November 19, 1991.

The above named national securities exchange has filed applications with the Securities and Exchange Commission ("Commission") pursuant to section 12(f)(1)(B) of the Securities Exchange Act of 1934 and Rule 12f-1 there under for unlisted trading privileges in the following securities:

Acme-Cleveland Corp. (Holding Co.)
Common Stock, \$1.00 Par Value (File No. 7-7559)

Amphenol Corp.
Class A Common Stock, \$0.001 Par Value (File No. 7-7560)

Argentina Fund, Inc.
Common Stock, \$0.01 Par Value (File No. 7-7561)

Bet Public Ltd.
American Depository Receipts, Class A
Common Stock, \$0.02 Par Value (File No. 7-7562)

East-West Europe Fund, Inc.
Common Stock, \$0.001 Par Value (File No. 7-7563)

Enron Corp.
Common Stock, \$10.00 Par Value (File No. 7-7564)

General Physics Corp.
Common Stock, \$0.025 Par Value (File No. 7-7565)

German Smaller Co's. Fund, Inc.
Common Stock, \$0.001 Par Value (File No. 7-7566)

Health Care & Retirement Corp.
Common Stock, \$0.01 Par Value (File No. 7-7567)

InterCapital Quality Municipal Investment Trust
Common Shares of Beneficial Interest, \$0.01 Par Value (File No. 7-7568)

Jenny Craig, Inc.
Common Stock, \$0.001 Par Value (File No. 7-7569)

Latin American Equity Fund, Inc.
Common Stock, \$0.001 Par Value (File No. 7-7570)

Morgan Stanley Emerging Markets Fund, Inc.
Common Stock, \$0.01 Par Value (File No. 7-7571)

PHM Corp.
Common Stock, \$0.01 Par Value (File No. 7-7572)

Presley Companies
Common Stock, \$0.01 Par Value (File No. 7-7573)

Scherer R.P. Corp.
Common Stock, \$0.01 Par Value (File No. 7-7574)

ShopKo Stores, Inc.
Common Stock, \$0.01 Par Value (File No. 7-7575)

Tiphook Plc

American Depository Shares (Representing the Right to Receive 4 Ordinary Shares of 10 P Each) (File No. 7-7576)
 Warnaco Group, Inc.
 Class A Common Stock, \$0.01 Par Value (File No. 7-7577)
 Advanced Magnetics, Inc.
 Common Stock, \$0.01 Par Value (File No. 7-7578)
 Greyhound Lines, Inc.
 Common Stock, \$0.01 Par Value (File No. 7-7579)
 Partners Preferred Yield, Inc.
 Common Stock, Series A, \$0.01 Par Value (File No. 7-7580)

These securities are listed and registered on one or more other national securities exchange and are reported in the consolidated transaction reporting system.

Interested persons are invited to submit on or before December 11, 1991, written data, views and arguments concerning the above-referenced applications. Persons desiring to make written comments should file three copies thereof with the Secretary of the Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549. Following this opportunity for hearing, the Commission will approve the applications if it finds, based upon all the information available to it, that the extensions of unlisted trading privileges pursuant to such applications are consistent with the maintenance of fair and orderly markets and the protection of investors.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

Jonathan G. Katz,

Secretary.

[FR Doc. 91-28264 Filed 11-22-91; 8:45 am]

BILLING CODE 8010-01-M

[Release No. 34-29952; File No. SR-DTC-91-16]

Self-Regulatory Organizations; The Depository Trust Company; Filing of Proposed Rule Change Relating to DTC's Proposed Deposit and Withdrawal at Custodian ("DWAC") Service

November 18, 1991.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 ("Act"), 15 U.S.C. 78s(b)(1), notice is hereby given that on July 17, 1991, The Depository Trust Company ("DTC") filed with the Securities and Exchange Commission ("Commission") the proposed rule change (SR-DTC-91-16) and, on October 29, 1991, amended the

proposed rule change¹ as described in Items I, II, and III below. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The proposed rule change establishes a Deposit and Withdrawal at Custodian ("DWAC") service that would supplement DTC's current deposit and withdrawal procedures.² The proposal would provide participants the opportunity to make deposits and withdrawals directly with a transfer agent for an issue evidenced by a balance certificate³ registered in the name of Cede & Co. and held for DTC by a transfer agent ("DTC Custodian"). Only issues eligible under DTC's Fast Automated Securities Transfer ("FAST") Program⁴ and certain other issues (including U.S. book-entry-only ("BEO") issues⁵ and certain limited certificates

¹ The amendment revises the form of agreement that transfer agents must sign to be able to use the DWAC service for securities issues that are eligible for deposit at DTC. Second, the amendment revises DTC's procedures to clarify that a custodian in the DWAC service must either accept or reject DWAC deposit and withdrawal instructions from DTC participants on the same day those instructions are received. Letter from Patricia H. Trainor, Associate Counsel, DTC, to Ester Saverson, Jr., Esq., Branch Chief, Division of Market Regulation, Commission (October 19, 1991).

² DWAC does not replace current DTC deposit and withdrawal services but supplements such services. Therefore, participants may continue to deposit and withdraw securities at DTC under existing DTC rules and procedures.

³ A balance certificate is held in the custody of and is maintained by a DTC Custodian and represents the balance of securities held in the name of Cede & Co. The total number of shares or units represented by a balance certificate increases and decreases daily based upon the amount of deposited or withdrawn securities.

⁴ Under DTC's FAST (Fast Automated Securities Transfer) program, instead securities being on deposit at DTC, DTC leaves securities in the custody of transfer agents in the form of balance certificates registered in the name of Cede & Co., DTC's nominee name (Securities Exchange Act Release No. 13342 (March 16, 1977), 42 FR 14792). Typically FAST transfer agents are banks. In cases where a non-bank FAST transfer agent participates in DWAC, the FAST procedures governing non-bank FAST transfer agents apply and the balance certificate in the custody of such transfer agent would not evidence the entire Cede & Co. position but must be limited to a minority of the quantity of securities registered in the name of Cede & Co.

⁵ BEO securities are certificated securities that are evidenced by one balance certificate registered in the name of Cede & Co. Beneficial owners generally cannot obtain negotiable certificates evidencing their ownership interests.

issues⁶) are eligible for DTC's DWAC service. Participants may initiate a DWAC deposit or withdrawal request using DTC's Participant Terminal System.⁷

To use DWAC for deposits or withdrawals of securities, participants must determine whether the appropriate DTC Custodian participates in the DWAC system and what its requirements are with respect to deposits and withdrawals of DWAC eligible securities. To facilitate this determination, DTC will maintain a current list of participating DTC Custodians and provide the same to participants on a regular basis. A participant, however, should contact the DTC Custodian regarding the custodian's procedures for the acceptance of a DWAC deposit or withdrawal, including any fee charged by the DTC Custodian, prior to submitting a DWAC deposit or withdrawal in order to minimize the possibility of such deposit or withdrawal being rejected.

To use DWAC to make a deposit of securities certificates, the participant notifies DTC over PTS that it has delivered or is delivering such securities to the DTC Custodian for deposit to the participant's DTC account. For non-certificated deposits, the participant notifies DTC that a deposit has been or will shortly be made into DTC's account at the DTC Custodian on behalf of the DTC participant. DTC would then make this deposit information available to the DTC Custodian over PTS. The DTC Custodian has until 6:30 p.m. that day to either approve or disapprove the deposit by acknowledging to DTC the acceptance or rejection of the deposit through PTS.⁸ If the DTC Custodian

⁶ An example of a limited certificate issue is where part of a global issue is represented in the U.S. by one certificate in the custody of a DTC custodian and the remainder is evidenced by one or more other certificates located elsewhere. For a comprehensive list of categories of DWAC eligible securities, see Letter from Patricia H. Trainor, Associate Counsel, DTC, to Ester Saverson Jr., Branch Chief, Division of Market Regulation, Commission (September 11, 1991).

⁷ PTS is DTC's electronic system that enables DTC and its participants to communicate. Securities Exchange Act Release No. 20519 (December 30, 1984), 49 FR 966.

⁸ According to DWAC procedures, if the DTC Custodian fails to act on an instruction by the end of the day, the instruction would be dropped and the participant must resubmit the instruction over PTS the next business day to allow the custodian to act on the instruction. The failure of a DTC Custodian to act on an instruction by the end of the day is deemed to be a rejected transfer and would be handled accordingly. Obviously, the DTC Custodian may not debit or credit DTC's account to reflect such instruction. See *supra* note 1.

accepts the deposit, it would effect a transfer of ownership that results in an increase in DTC's account on the issuer's books and the balance certificate held for DTC.⁹ Once notified of the acceptance of the deposit by the DTC Custodian, DTC would credit the participant's account by the amount deposited and contemporaneously increase DTC's record of securities on the balance certificate held by the DTC Custodian.

To use DWAC for a withdrawal of securities, the participant would instruct DTC through PTS to withdraw the securities from its account. After DTC receives the instruction from a participant, DTC checks the participant's account to determine whether the participant has a sufficient quantity of securities required for such a withdrawal. If so, DTC would debit the participant's account for subject securities and credit an internal DTC account to reflect a pending withdrawal. DTC would forward the withdrawal instruction through PTS to the appropriate DTC Custodian. The DTC Custodian has until 6:30 p.m. that day to either approve or disapprove the withdrawal by acknowledging to DTC the acceptance or rejection of the withdrawal instruction through PTS.¹⁰ By approving the withdrawal, the DTC Custodian acknowledges that it has completed the withdrawal request and has decreased the amount of securities held for DTC, as evidenced by the balance certificate.¹¹ Once accepted by the DTC Custodian, DTC would make the appropriate entries on its records and notify the participant that DTC has debited the participant's DTC account and that the DTC Custodian, in its capacity as transfer agent, has received the instructions to credit securities to another account. If the issue is certificated, the participant may collect its certificates from the DTC Custodian; otherwise, the participant may obtain a confirmation of position from the transfer agent.

DTC proposes to charge participants initiating DWAC deposits and withdrawals \$0.62 for each deposit and withdrawal.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, DTC included statements concerning the purpose of and statutory basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. Set forth in sections (A), (B), and (C) below are summaries of the most significant aspects of such statements.

(A) Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

The proposed rule change has three main purposes. The first is to eliminate unnecessary creation, cancellation, and movement of securities certificates. The second is to facilitate and further automate transfers of BEO or limited certificate securities between DTC and other custodians' accounting systems. The third is to increase the extent to which PTS can be used for communications between DTC, its participants, and DTC Custodians when the number of securities evidenced by the balance certificate (in the DTC Custodian's custody) is reduced or increased.

The proposed rule change also would supplement current physical deposit and withdrawal procedures and will replace current procedures for Direct Transfer Agent Deposit ("DTAD") and for Certificate on Demand Exceptional Instruction ("CODX").

The proposed rule change is consistent with the requirements of section 17A of the Act, as amended, and the rules and regulations thereunder because it facilitates the prompt and accurate clearance and settlement of securities transactions by reducing the need for manual handling of certificates and fosters cooperation and coordination between DTC and other persons engaged in the clearance and settlement of securities transactions.

(B) Self-Regulatory Organization's Statement on Burden on Competition

DTC does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

(C) Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Letters received in 1988 and 1989 from The Securities Transfer Association, Inc. and from DTC participants Smith Barney and U.S. Trust prompted DTC to include a proposal for a service similar to DWAC in its 1989 Program Agenda. In response to the rule filing, DTC received two comment letters from U.S. Trust and Investors Fiduciary Trust Company. The comment letters and DTC's responses are included in DTC's filing.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within thirty-five days of the date of publication of this notice in the *Federal Register* or within such longer period: (i) As the Commission may designate up to ninety days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which DTC consents, the Commission will:

(a) By order approve such proposed rule change or

(b) Institute proceedings to determine whether the proposed rule change should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any persons, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Section, 450 Fifth Street, NW., Washington, DC 20549. Copies of such filing will also be available for inspection and copying at the principal office of DTC. All submissions should refer to File No. SR-DTC-91-16 and should be submitted by December 16, 1991.

⁹ A DTC Custodian wishing to participate in the DWAC program indicates in an agreement that it understands the effect of an approval of a DWAC instruction prior to having the DWAC function added to its PTS terminal. *Id.*

¹⁰ See *supra* note 8.

¹¹ See *supra* note 9.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

Margaret H. McFarland,
Deputy Secretary.

[FR Doc. 91-28253 Filed 11-22-91; 8:45 am]

BILLING CODE 8010-01-M

[Release No. 34-29958; No. SR-MSE-91-10]

**Self-Regulatory Organizations;
Proposed Rule Change by Midwest
Stock Exchange, Inc. Relating to a
Pilot Program for Stopped Orders in
Minimum Variation Markets**

November 18, 1991.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 ("Act"), 15 U.S.C. 78s(b)(1), notice is hereby given that on May 30, 1991, the Midwest Stock Exchange, Inc. ("MSE" or "Exchange") filed with the Securities and Exchange Commission ("Commission") the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the self-regulatory organization. On June 7, 1991, the MSE amended the proposed rule change to request that the Commission approve the proposal as a one year pilot program.¹ On November 7, 1991, the MSE submitted a second amendment to the Commission to clarify the operation of the proposed rule change.² The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

**I. Self-Regulatory Organization's
Statement of the Terms of Substance of
the Proposed Rule Change**

The Exchange proposes an addition to its Interpretations and Policies under Article XX, Rule 37 (Guaranteed Execution System). The proposed interpretation and policy statement explains what the Exchange's procedure will be regarding the execution of "stopped" orders in minimum variation markets (generally $\frac{1}{4}$ th). The text of the proposed rule change is as follows:

Additions are *italicized*, Deletions [bracketed].

Article XX, Rule 37 is amended as follows:

Guaranteed Execution System

Rule 37. No change in text.

1. through 5. No change in text.

6. Since executions are guaranteed on the basis of the best bid or offering, the

order may be executed out of the primary market range for the day but in a Dual Trading System issue a stop must be granted if requested.

7. No change in text.

*** * * Interpretations and Policies:**

.01 No change in text.

.02 No change in text.

.03 *With regard to paragraph 6 of this Rule, in the case of a minimum variation market, a stopped sell order will not be filled until a transactions takes place at the bid price or lower or the displayed MSE share volume at the offering has been exhausted. A stopped buy order will not be filled until a transaction takes place at the offering price or higher or the displayed MSE share volume at the bid has been exhausted. Notwithstanding the foregoing, all orders stopped pursuant to this Interpretation and Policy .03 shall be executed by the end of the trading day on which such order was stopped at no worse than the stopped price.*

**II. Self-Regulatory Organization's
Statement of the Purpose of, and
Statutory Basis for, the Proposed Rule
Change**

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The self-regulatory organization has prepared summaries, set forth in sections (A), (B), and (C) below, of the most significant aspects of such statements.

**A. Self-Regulatory Organization's
Statement of the Purpose of, and
Statutory Basis for, the Proposed Rule
Change**

The purpose for the rule change is to establish a procedure regarding the execution of "stopped" market orders in minimum variation markets (usually an $\frac{1}{4}$ th spread market). Exchange Rules now require specialists to grant stops if an out of range³ execution will result, regardless of the spread.⁴ The Exchange also has a policy regarding the execution of stopped market orders generally. However, the Exchange believes it is necessary to establish a separate policy for executing stopped market orders when there is a minimum variation market.

³ "Out of range" means either higher or lower than the range in which the security traded during a particular trading day.

⁴ See Exchange Rule 37 (Article XX), paragraph 6.

The Exchange's current policy regarding the execution of stopped orders is to execute them after the next primary market sale on a "next no better" basis.⁵ In a minimum variation market, this policy frequently causes the anomalous result of requiring the execution of all pre-existing orders even if those orders are not otherwise entitled to be filled.⁶

The Exchange's proposed policy will prevent unintended results by requiring the execution of stopped market orders in minimum variation markets after a transaction takes place on the primary market at the stopped price or higher, or after the applicable MSE share volume is exhausted. In no event will a stopped order be executed at a price inferior to the stop price.⁷ Moreover, the proposed policy will require that all orders stopped pursuant to the policy be executed by the end of the trading day on which the order was stopped at no worse than the stopped price. The proposed policy will continue to benefit customers because they might receive a better price than the stop price, yet it also protects MSE specialists by eliminating their exposure to executing potentially large amounts of pre-existing bids or offers when such executions

⁵ "Next no better" means that a customer who requests a stop at a specific price won't do any worse than that price and could do better.

⁶ For example, assume the market in ABC stock is 20-20 $\frac{1}{2}$; 50 $\times$ 50 with $\frac{1}{4}$ th being out of range. A customer places an order with the MSE specialist to buy 100 shares of ABC at the market and a stop is effected. The order is stopped at 20 $\frac{1}{2}$ and the MSE specialist includes the order in his quote by bidding the 100 shares at 20. If the next sale on the primary market is for 100 shares at 20, current Exchange policy requires the specialist to execute the stopped market order at 20. However, because the stopped market order does not have time or price priority, its execution triggers the requirement for the MSE specialist to execute all pre-existing bids (in this case 5,000 shares) based on the Exchange's rules of priority and precedence. This is so even though the pre-existing bids were not otherwise entitled to be filled. See MSE Rule 16 (Article XX).

In the above example, Exchange Rule 37 (Article XX) requires the MSE specialist to fill orders at the limit price only if such orders would have been filled had they been transmitted to the primary market. Therefore, the 100 share print at 20 in the primary market would cause at most 100 of the 5,000 share limit order to be filled on the MSE. However, because the Exchange's current policy regarding stopped orders requires the 100 share stopped market order to be filled, all pre-existing bids at the same price must also be filled in accordance with Exchange Rule 16 (Article XX).

⁷ Exchange Rule 28 (Article XX) states: An agreement by a member or member organization to "stop" securities at a specified price shall constitute a guarantee of the purchase or sale by him or it of the securities at the price or its equivalent in the amount specified.

If an order is executed at a less favorable price than that agreed upon, the member or member organization which agreed to stop the securities shall be liable for an adjustment of the difference between the two prices.

¹ See letter from Daniel J. Liberti, Associate Counsel, MSE to Mary Revell, Branch Chief, Commission, dated June 6, 1991.

² See letter from Daniel J. Liberti, Associate Counsel, MSE to Mary Revell, Branch Chief, Commission, dated November 6, 1991.

would otherwise not be required under Exchange rules.

The proposed rule change is consistent with Section 6(b)(5) of the Act in that it is designed to promote just and equitable principles of trade.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange believes that no burdens will be placed on competition as a result of the proposed rule change.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Comments were neither solicited nor received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within 35 days of the date of publication of this notice in the Federal Register or within such longer period (i) as the Commission may designate up to 90 days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the self-regulatory organization consents, the Commission will:

(A) By order approve the proposed rule change, or

(B) Institute proceedings to determine whether the proposed rule change should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the commission, and all written communications relating to the proposed rule change between the Commission and any persons other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Section, 450 Fifth Street, NW., Washington, DC 20549. Copies of such filing will also be available for inspection and copying at the principal office of the MSE. All submissions should refer to File No. SR-MSE-91-10 and should be submitted by December 16, 1991.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 91-28259 Filed 11-22-91; 8:45 am]

BILLING CODE 8010-01-M

Self-Regulatory Organizations; Midwest Stock Exchange, Inc.; Application for Unlisted Trading Privileges In an Over-the-Counter Issue and to Withdraw Unlisted Trading Privileges In an Over-the-Counter Issue

November 18, 1991.

On November 8, 1991, the Midwest Stock Exchange, Inc. submitted an application for unlisted trading privileges ("UTP") pursuant to section 12(f)(1)(C) of the Securities Exchange Act of 1934 ("Act") in the following over-the-counter ("OTC") security, i.e., a security not registered under section 12(b) of the Act.

File No.	Symbol	Issuer
7-7503.....	WHOO.....	Waterhouse Investor Services, Inc. Common Stock: \$0.01 par value.

The above-referenced issue is being applied for as an expansion of the exchange's program in which OTC securities are being traded pursuant to the granting of UTP.

The MSE also applied to withdraw UTP pursuant to section 12(f)(4) of the Act on the following issue:

File No.	Symbol	Issuer
7-7504.....	TATE.....	Ashton-Tate Corp. Common Stock: \$0.01 par value.

The Exchange requests that Ashton-Tate Corp. be removed from the program due to its acquisition by Borland International, Inc.

Comments

Interested persons are invited to submit, on or before December 9, 1991, written comments, data, views and arguments concerning this application. Persons desiring to make written comments should file three copies with the Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549.

Commentators are asked to address whether they believe the requested grant of UTP would be consistent with section 12(f)(2), which requires that, in considering an application for extension

of UTP in an OTC security, the Commission consider, among other matters, the public trading activity in such security, the character of such trading, the impact of such extension on the existing markets for such security, and the desirability of removing impediments to and the progress that has been made toward the development of a national market system.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 91-28265 Filed 11-22-91; 8:45 am]

BILLING CODE 8010-01-M

Self-Regulatory Organizations; Applications for Unlisted Trading Privileges and of Opportunity for Hearing; Midwest Stock Exchange, Inc.

November 19, 1991.

The above named national securities exchange has filed applications with the Securities and Exchange Commission ("Commission") pursuant to section 12(f)(1)(B) of the Securities Exchange Act of 1934 and Rule 12f-1 thereunder for unlisted trading privileges in the following securities:

Amphenol Corporation

Class A Common Stock, \$0.001 Par Value (File No. 7-7556)

St. Paul Companies, Inc.

Common Stock, No Par Value (File No. 7-7557)

Wabash National Corporation

Common Stock, \$0.01 Par Value (File No. 7-7558)

These securities are listed and registered on one or more other national securities exchange and is reported in the consolidated transaction reporting system.

Interested persons are invited to submit on or before December 11, 1991, written data, views and arguments concerning the above-referenced application. Persons desiring to make written comments should file three copies thereof with the Secretary of the Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549. Following this opportunity for hearing, the Commission will approve the application if it finds, based upon all the information available to it, that the extensions of unlisted trading privileges pursuant to such application is consistent with the maintenance of fair and orderly markets and the protection of investors.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

Jonathan G. Katz,
Secretary.

[FR Doc. 91-28266 Filed 11-22-91; 8:45 am]

BILLING CODE 8010-01-M

[Release No. 34-29955; File No. SR-NYSE-91-38]

Self-Regulatory Organizations; Filing of Proposed Rule Change by New York Stock Exchange, Inc.

November 18, 1991.

In the matter of Adding Exchange Rules 704, 705, 780.10(b), 80A (c) and (d), and 116.30 to the List of Exchange Rule Violations and Fines Under Rule 476A and Amending Minor Rule Violation Enforcement and Reporting Plan.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 ("Act"), 15 U.S.C. 78s(b)(1), notice is hereby given that on November 6, 1991, the New York Stock Exchange, Inc. ("NYSE" or "Exchange") filed with the Securities and Exchange Commission ("Commission") the proposed rule change as described in Items I, II and III below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

This proposal would revise the "List of Exchange Rule Violations and Fines Applicable Thereto Pursuant to Rule 476A" ("List") for imposition of fines for minor violations of NYSE rules and/or policies by adding to the List certain Exchange rules pertaining to options and two rules pertaining to equities: Rule 704 which concerns position limits; Rule 705 which concerns exercise limits; Rule 780.10(b) which requires the delivery of an "exercise advice" to the Exchange for exercises of a certain size; Rule 80A, paragraphs (c) and (d), which impose tick requirements on certain orders on days when the Dow Jones Industrial Average¹ has moved up or down 50 points from the previous close; and Rule 116.30 which contains restrictions on the specialist's stopping stock.² The Exchange believes it is

appropriate to make the failure to comply with the provisions of the above-named rules subject to the possible imposition of a fine under NYSE Rule 476A procedures.³

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Self-regulatory organization has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

NYSE Rule 476A provides that the Exchange may impose a fine, not to exceed \$5,000, on any member, member organization, allied member, approved person, or registered or non-registered employee of a member or member organization for a minor violation of certain specified Exchange rules.⁴

The purpose of the NYSE Rule 476A procedure is to provide for a response to a rule violation when a meaningful sanction is appropriate, but when initiation of a disciplinary proceeding under NYSE Rule 476 is not suitable, because such a proceeding would be more costly and time-consuming than would be warranted given the minor nature of the violation. Rule 476A provides for an appropriate response to minor violations of certain Exchange

Howard Kramer, Assistant Director, Division of Market Regulation, Commission, dated November 5, 1991. The Commission approved the Plan, embodied in NYSE Rule 476A, in Securities Exchange Act Release No. 22415 (September 17, 1985), 50 FR 38600, relieving the NYSE of the current reporting requirements imposed under section 19(d)(1). The Commission notes that Rule 476A fines in excess of \$2,500 are not considered assessed pursuant to the Plan and, accordingly, must be reported under section 19(d)(1).

³ NYSE Rule 476A provides that the Exchange may designate certain rules violations as minor and issue a citation with a corresponding fine, not to exceed \$5,000, to certain persons for an infraction of the delineated rules. The penalized party may either accept the citation or seek a full disciplinary hearing. In addition, the Exchange has the option of instituting a full disciplinary hearing for any violation of rules included on the Rule 476A List.

⁴ A list of the NYSE rules subject to Exchange Rule 476A procedures is contained under Supplementary Material to NYSE Rule 476A and is available from the Commission and the NYSE.

rules while preserving the due process rights of the party accused through specified, required procedures. The List of rules which are eligible for Rule 476A procedures specifies those rule violations which may be the subject of fines under the rule and also includes a schedule of fines.

In SR-NYSE-84-27, which initially set forth the provisions and procedures of NYSE Rule 476A, the Exchange indicated it would amend the List of rules from time to time, as it considered appropriate, in order to phase-in the implementation of Rule 476A as experience with it was gained.⁵ The Exchange's regulatory divisions have amended the list since its initial implementation to include either existing rules of newly approved ones, which are appropriate for inclusion in this particular disciplinary process when violations occur.⁶

The Exchange is presently seeking approval to add certain Exchange rules pertaining to options to the List of rules subject to possible imposition of fines under NYSE Rule 476A procedures. These rules are: Rule 704 which imposes position limits for options; Rule 705 which imposes exercise limits for options; and Rule 780.10(b) which requires the delivery of an "exercise advice" to the Exchange for exercises of a certain size.

In addition, the Exchange is seeking approval to add Exchange Rules 80A (c) and (d) and 116.30 to the List of rules subject to possible imposition of fines under Rule 476A procedures. Rules 80A imposes tick requirements on certain order on days when the Dow Jones Industrial Average has moved 50 points from the previous close. Rule 116.30 contains restrictions on a specialist's ability to stop stock.

The purpose of the proposed change to NYSE Rule 476A is to facilitate the Exchange's ability to induce compliance with all aspects of the above-named rules.

⁵ See Securities Exchange Act Release No. 21688 (January 25, 1985), 50 FR 5025.

⁶ See Securities Exchange Act Releases No. 22490 (October 2, 1985), 50 FR 41084 (order granting accelerated approval to File No. SR-NYSE-85-30); No. 23104 (April 11, 1986), 51 FR 13307 (approving file No. SR-NYSE-86-12); No. 24985 (October 5, 1987), 52 FR 41643 (approving File No. SR-NYSE-86-21); No. 25763 (May 27, 1988), 53 FR 20925 (approving File No. RY-NYSE-87-10); No. 27702 (February 12, 1990), 55 FR 6139 (approving pilot of 5 rules until October 5, 1990, File No. SR-NYSE-90-04); No. 27878 (April 4, 1990), 55 FR 13345 (approving File No. SR-NYSE-89-44); No. 28003 (May 8, 1990), 55 FR 20004 (approving File No. SR-NYSE-90-09); No. 28505 (October 2, 1990), 55 FR 41288 (permanently approving File No. SR-NYSE-90-04); No. 28995 (March 21, 1991), 56 FR 12967 (approving File No. SR-NYSE-91-04).

¹ "Dow Jones Industrial Average" is a service mark of Dow Jones & Co., Inc.

² The NYSE has also requested approval, under Rule 19d-1(c)(2), 17 CFR 240.19d-1(c)(2), to amend its Rule 19d-1 minor rule violation enforcement and reporting plan ("Plan") to include the foregoing Exchange rules. See letter from James E. Buck, Senior Vice President and Secretary, NYSE, to

The Exchange believes failure to comply with the requirements of these rules should be addressed with an appropriate sanction and seeks Commission approval to add violations of these requirements to the NYSE Rule 476A List.

2. Statutory Basis

The proposed rule change will advance the objectives of section 6(b)(6) of the Act in that it will provide a procedure whereby member organizations can be "appropriately disciplined" in those instances when a rule violation is minor in nature, but a sanction more serious than a warning or cautionary letter is appropriate. The proposed rule change provides a fair procedure for imposing such sanctions, in accordance with the requirements of sections 6(b)(7) and 6(d)(1) of the Act.

B. Self-Regulatory Organization's Statement of Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement of Comments on the Proposed Rule Change Received From Members, Participants or Others

The Exchange has neither solicited nor received written comments on the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within 35 days of the publication of this notice in the *Federal Register* or within such other period (i) as the Commission may designate up to 90 days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the self-regulatory organization consents, the Commission will:

(A) By order approve the proposed rule change, or

(B) Institute proceedings to determine whether the proposed rule change should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing. Persons making written submission should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549. Copies of the submission, all subsequent amendments, all written statement with respect to the proposed rule change that are filed with

the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying at the Commission's Public Reference Section, 450 Fifth Street, NW., Washington, DC 20549. Copies of such filing will also be available for inspection and copying at the principal office of the NYSE. All submissions should refer to File No. SR-NYSE-91-38 and should be submitted by December 16, 1991.

For the Commission, by the Division of Market Regulations, pursuant to delegated authority.

Margaret H. McFarland,
Deputy Secretary.

[FR Doc. 91-28260 Filed 11-22-91; 8:45 am]

BILLING CODE 8010-01-M

Self-Regulatory Organizations; Applications for Unlisted Trading Privileges and of Opportunity for Hearing; Pacific Stock Exchange, Inc.

November 18, 1991.

The above named national securities exchange has filed applications with the Securities and Exchange Commission ("Commission") pursuant to section 12(f)(1)(B) of the Securities Exchange Act of 1934 and Rule 12f-1 thereunder for unlisted trading privileges in the following securities:

Abiomed, Inc.

Common Stock, \$.01 Par Value (File No. 7-7536)

Bet Holdings, Inc.

Class A Common Stock, \$.02 Par Value (File No. 7-7537)

Exploration Company of Louisiana

Common Stock, \$.01 Par Value (File No. 7-7538)

CML Group, Inc.

Common Stock, \$.10 Par Value (File No. 7-7539)

Damon Corporation

Common Stock, \$.01 Par Value (File No. 7-7540)

Delta Woodside Industry, Inc.

Common Stock, \$.01 Par Value (File No. 7-7541)

Enterra Corp.

Common Stock, \$1.00 Par Value (File No. 7-7542)

Exel Limited

Ordinary Shares, \$.01 Par Value (File No. 7-7543)

First Financial Management Corp.

Common Stock, \$.10 Par Value (File No. 7-7544)

Gaylord Entertainment Co.

Common Stock, \$.01 Par Value (File No. 7-7545)

Global Natural Resources, Inc.

Common Stock, \$1.00 Par Value (File No. 7-7546)

Illinois Central Corp.

Common Stock, \$.001 Par Value (File No. 7-7547)

National City Corp.

Common Stock, \$.40 Par Value (File No. 7-7548)

Preferred Health Care

Common Stock, \$.01 Par Value (File No. 7-7549)

Sensormatic Electronics Corp.

Common Stock, \$.01 Par Value (File No. 7-7550)

American Health Properties

Common Stock, \$.01 Par Value (File No. 7-7551)

Meditrust

Shares of Beneficial Interest, No Par Value (File No. 7-7552).

These securities are listed and registered on one or more other national securities exchange and are reported in the consolidated transaction reporting system.

Interested persons are invited to submit on or before December 11, 1991, written data, views and arguments concerning the above-referenced application. Persons desiring to make written comments should file three copies thereof with the Secretary of the Securities and Exchange Commission, 450 5th Street, NW., Washington, DC 20549. Following this opportunity for hearing, the Commission will approve the application if it finds, based upon all the information available to it, that the extensions of unlisted trading privileges pursuant to such applications are consistent with the maintenance of fair and orderly markets and the protection of investors.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

Jonathan G. Katz,
Secretary.

[FR Doc. 91-28267 Filed 11-22-91; 8:45 am]

BILLING CODE 8010-01-M

[Release No. 34-29950; International Series No. 345; File No. SR-PSE-91-25]

Self-Regulatory Organizations; Filing of Proposed Rule Change by the Pacific Stock Exchange, Inc. Relating to the Listing of Warrants Based on the Europe-Australia-Far East ("EAFE") Index

November 18, 1991.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 ("Act"), 15 U.S.C. 78s(b)(1), notice is hereby given that on October 22, 1991, the Pacific Stock Exchange, Inc. ("PSE" or "Exchange") filed with the Securities and Exchange Commission

("Commission") the proposed rule change as described in Items I, II and III below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to approve for listing and trading under PSE Rule 3.2 (Index Warrants) warrants based on the Europe-Australia-Far-East ("EAFE") Index that Morgan Stanley Capital International ("MSCI") owns, calculates and disseminates. The EAFE Index currently consists of 1,068 of the most highly capitalized and actively-traded stocks on stock exchanges located in Australia, Japan and 16 other countries throughout Europe and the Far East.

The text of the proposed rule is available at the Office of the Secretary, PSE, and at the Commission.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of, and statutory basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The self-regulatory organization has prepared summaries, set forth in sections (A), (B), and (C) below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

Under Rule 3.2 (Index Warrants) the PSE may approve for listing index warrants based on established foreign and domestic indexes. The PSE is proposing to list index warrants based on the EAFE Index, an internationally-recognized, capitalization-weighted, broad-based index representing the performance of an unmanaged portfolio of stocks listed for trading on stock markets in Europe, Australia and the Far East. As of March 31, 1991, the Index

consisted of 1,068 stocks traded on stock exchanges located in 18 countries.¹ The Index has been calculated since January, 1970.

MSCI currently disseminates the EAFE Index throughout the United States and other parts of the world by assorted publications and market data vendors. MSCI owns the EAFE Index and is responsible for calculating and maintaining the Index. It monitors corporate developments relating to the Index's component stocks and makes determinations as to additions to and deletions from the EAFE Index. MSCI has arranged to have an independent third party, The Economist, review its recommendations for additions and deletions in order to confirm that those recommendations conform to the stated methodology.

EAFE Index warrant issues will conform to the listing guidelines under PSE Rule 3.2 which provide that (1) the issuer shall have assets in excess of \$100,000,000 and otherwise substantially exceed the Exchange's size and earnings requirements; (2) the term of the warrants shall be for a period of at least one year from the date of issuance; and (3) the minimum public distribution of such issues shall be 1,000,000 warrants together with a minimum of 400 public holders, and have a minimum aggregate market value of \$4,000,000.

EAFE index warrants will be direct obligations of their issuer subject to cash-settlement during their term, and either exercisable throughout their life (i.e., American style) or exercisable only on their expiration date (i.e., European style). Upon exercise, or at the warrant expiration date (if not exercisable prior to such date), the holder of a warrant structured as a "put" would receive payment in U.S. dollars to the extent that the EAFE Index settlement price has declined below a pre-stated strike price. Conversely, holders of a warrant structured as a "call" would, upon exercise or at expiration, receive payment in U.S. dollars to the extent that the EAFE Index settlement price has increased above the pre-stated strike price. If "out-of-the-money" at the time of expiration, the warrants would expire worthless.

The PSE has adopted suitability standards applicable to recommendations to customers of index warrants and transactions in customer

accounts. Rule 9.18(c) applies the options suitability standard to recommendations regarding index warrants, and recommends that index warrants be sold only to options-approved accounts. Rule 9.19(c)(2) requires a Senior Registered Options Principal or a Registered Options Principal to approve and initial a discretionary order in index warrants on the day the order is entered. In addition, the Exchange, prior to the commencement of trading, will distribute a circular to its membership calling attention to specific risks associated with warrants on the EAFE Index.

In the approval order establishing a regulatory framework for index warrants listed on the PSE,² the Commission noted that, with respect to foreign index warrants, there should be an adequate mechanism for sharing surveillance information with respect to the index's component stocks. In this regard, the PSE has entered into information sharing agreements with the regulatory authorities of a number of constituent countries and is seeking to enter into such agreements with the regulatory authorities of other constituent countries to provide for the sharing of necessary information between the Exchange and those authorities to fulfill their respective regulatory responsibilities.

The Exchange believes that the proposed rule change is consistent with section 6(b) of the Act, in general, and furthers the objectives of section 6(b)(5), in particular, in that it is designed to prevent fraudulent and manipulative acts and practices and to promote just and equitable principles of trade, and is not designed to permit unfair discrimination between customers, issuers, brokers or dealers.

B. Self-Regulatory Organization's Statement on Burden on Competition

The PSE does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From

¹ The weighting of the EAFE Index by country is as follows: (1) Australia (2.40%); (2) Austria (0.47%); (3) Belgium (1.18%); (4) Denmark (0.75%); (5) Finland (0.40%); (6) France (5.42%); (7) Germany (5.88%); (8)

Hong Kong (1.64%); (9) Italy (2.38%); (10) Japan (50.86%); (11) Netherlands (2.67%); (12) New Zealand (0.18%); (13) Norway (0.44%); (14) Singapore/Malaysia (1.21%); (15) Spain (1.99%); (16) Sweden (1.74%); (17) Switzerland (3.22%); and (18) United Kingdom (17.38%).

² Securities Exchange Act Release No. 27919 (April 19, 1990), 55 FR 19696.

Members, Participants, or Others

The Exchange has neither solicited nor received comments with respect to the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within 35 days of the date of publication of this notice in the *Federal Register* or within such longer period (i) as the Commission may designate up to 90 days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the self-regulatory organization consents, the Commission will:

- (a) By order approve such proposed rule change, or
- (b) Institute proceedings to determine whether the proposed rule change should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Section, 450 Fifth Street, NW., Washington, DC. Copies of such filing will also be available for inspection and copying at the principal office of the above-mentioned self-regulatory organization. All submissions should refer to the file number in the caption above and should be submitted by December 16, 1991.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

Margaret H. McFarland,
Deputy Secretary.

[FR Doc. 91-28261 Filed 11-22-91; 8:45 am]

BILLING CODE 8010-01-M

[Release No. 34-29951; International Series Release No. 345; File No. SR-PSE-91-26]

Self-Regulatory Organizations; Filing of Proposed Rule Change by the Pacific Stock Exchange, Inc. Relating to Listing of Index Warrants Based on the Financial Times-Stock Exchange Eurotrack 100 Index

November 18, 1991.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 ("Act"), 15 U.S.C. 78s(b)(1), notice is hereby given that on October 22, 1991, the Pacific Stock Exchange, Inc. ("PSE" or "Exchange") filed with the Securities and Exchange Commission ("Commission") the proposed rule change as described in Items I, II and III below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

II. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The PSE proposes to approve for listing and trading under PSE Rule 3.2 index warrants based on the Financial Times-Stock Exchange Eurotrack 100 Index ("Eurotrack 100 Index" or "Index"), an index that represents 100 of the most highly capitalized and actively traded stocks of non-British European issuers traded on the London Stock Exchange ("LSE").

I. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of, and statutory basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The self-regulatory organization has prepared summaries, set forth in sections (A), (B), and (C) below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

Under PSE Rule 3.2 (Warrants), the Exchange may list index warrants based on established foreign and domestic indices. The PSE is now proposing to list index warrants based on the Eurotrack 100 Index, an internationally recognized, capitalization-weighted stock index

representing 100 of the most highly capitalized and actively traded stocks of non-British European issuers traded on the LSE. The Eurotrack 100 Index currently is calculated and published in Deutschmarks each minute from 9:45 a.m. to 3:30 p.m. (London Time) and is currently disseminated in the United States by the LSE and by market data vendors.¹

The LSE is responsible for calculating and maintaining the Index. The Financial Times monitors corporate developments relating to the component stocks of the Index and licenses the use of its name to the LSE for the purposes of the Index. In addition to the LSE and the Financial Times, an "index working committee" was formed to assist with the design and development of the Index.

The PSE represents that such Index warrant issues will conform to the listing guidelines under PSE Rule 3.2, which provide that (1) the issuer shall have assets in excess of \$100,000,000 and otherwise substantially exceed the Exchange's size and earnings requirements; (2) the term of the warrants shall be for a period of at least one year from the date of issuance; and (3) the minimum public distribution of such issues shall be 1,000,000 warrants together with a minimum of 400 public holders, and the warrants shall have an aggregate market value of \$4,000,000.

FT-SE Eurotrack 100 warrants will be direct obligations of their issuer subject to cash-settlement during their term, and either exercisable throughout their life (*i.e.*, American style) or exercisable only on their expiration date (*i.e.*, European style). Upon exercise, or at the warrant expiration date (if not exercisable prior to such date), the holder of a warrant structured as a "put" would receive payment in U.S. dollars to the extent that the Eurotrack 100 has declined below a pre-stated cash settlement value. Conversely, holders of a warrant structured as a "call" would, upon exercise or at expiration, receive payment in U.S. dollars to the extent that the Eurotrack 100 has increased above the pre-stated cash settlement value. If "out-of-the-money" at the time of expiration, the warrants would expire worthless.

The PSE has adopted suitability standards applicable to recommendations to customers of index warrants and transactions in customer

¹ For a more complete description of the Eurotrack 100, see the proposal by the Chicago Board Options Exchange to trade options on the Eurotrack 100, Securities Exchange Act Release No. 29045 (April 4, 1991), 56 FR 14553.

accounts. Specifically, Exchange Rule 9.18(c) applies the options suitability standard to recommendations regarding Index warrants. The Exchange also recommends that Index warrants be sold only to options-approved accounts. In addition, Exchange Rule 9.18(c) requires a Senior Registered Options Principal or a Registered Options Principal to approve and initial a discretionary order in Index warrants on the day the order is entered. Finally, the PSE, prior to the commencement of trading in Eurotrack 100 Index warrants, will distribute a circular to its membership calling attention to specific risks associated with warrants on the Eurotrack 100 Index.

The Exchange has entered into an agreement with The Securities and Futures Authority, Ltd. ("SFA") that provides for the sharing of necessary information between the Exchange and SFA to fulfill their respective regulatory responsibilities.

The Exchange believes that the proposed rule change is consistent with the requirements of the Act, and, in particular, section 6(b)(5), as the rules governing warrants are designed to prevent fraudulent and manipulative acts and practices and to promote just and equitable principles of trade, and are not designed to permit unfair discrimination between customers, issuers, brokers or dealers.

B. Self-Regulatory Organization's Statement on Burden on Competition

The PSE does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

The Exchange has neither solicited nor received comments on the proposed changes.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within 35 days of the date of publication of this notice in the *Federal Register* or within such longer period (i) as the Commission may designate up to 90 days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the self-regulatory organization consents, the Commission will:

(a) By order approve such proposed rule change, or

(b) Institute proceedings to determine whether the proposed rule change should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Section, 450 Fifth Street, NW., Washington, DC. Copies of such filing will also be available for inspection and copying at the principal office of the above-mentioned self-regulatory organization. All submissions should refer to the file number in the caption above and should be submitted by December 16, 1991.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

Margaret H. McFarland,
Deputy Secretary.

[FR Doc. 91-28262 Filed 11-22-91; 8:45 am]
BILLING CODE 8010-01-M

[Release No. 34-29954; File No. SR-PSE-91-37]

Self-Regulatory Organizations; Filing and Immediate Effectiveness of Proposed Rule Change by the Pacific Stock Exchange, Inc. Relating to Adoption of Registration Fees for Registered Representatives and Registered Options Principals

November 18, 1991.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 ("Act"), 15 U.S.C. 78s(b)(1), notice is hereby given that on October 28, 1991, the Pacific Stock Exchange, Inc. ("PSE" or "Exchange") filed with the Securities and Exchange Commission ("Commission") the proposed rule change is described as Items I, II and III below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The PSE is submitting to the Commission a rule change relating to the implementation of registration fees for Registered Representatives ("RR") and Registered Options Principals ("ROP").

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The self-regulatory organization has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to implement three new minimal fees that will be paid by member organizations to maintain, apply for, and transfer RR or ROP registrations.¹ First, the new fee will be \$10.00 per year to maintain an RR or ROP registration. Second, the fee will be \$10.00 per applicant for a new RR or ROP registration. And third, there will be a \$10.00 fee for transferring an RR or ROP registration. These fees will offset the costs related to the Exchange's market surveillance programs and routine Designated Examining Authority ("DEA") activities, as well as the processing of registrations. The Exchange has no other regulatory oversight fee to offset the costs of these programs and activities. The PSE notes that these fees are similar to ones imposed by the New York Stock Exchange ("NYSE"), National Association of Securities Dealers, American Stock Exchange, and Chicago Board Options Exchange for RRs and ROPs. For example, the NYSE charges the following fees for RRs and ROPs: (1) \$40.00 to maintain an RR or ROP registration; (2) \$65.00 per applicant for a new RR or ROP; and (3) \$43.00 for an RR or ROP transfer.

¹ RRs and ROPs are required to register with and be approved by the Exchange pursuant to PSE Rules 9.26 and 9.27.

2. Statutory Basis

The PSE believes that the proposed rule change is consistent with section 6(b) of the Act in general and furthers the objectives of section 6(b)(4) in particular in that the proposal provides for the equitable allocation of reasonable dues, fees and charges among the Exchange's members and issuers and other persons using its facilities.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change imposes a burden on competition.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants or Others

Written comments on the proposed rule change were neither solicited nor received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Because the foregoing rule change establishes or changes a due, fee, or other charge imposed by the Exchange, it has become effective pursuant to section 19(b)(3)(A) of the Act and subparagraph (e) of Rule 19b-4 thereunder. At any time within 60 days of the filing of such proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 50 Fifth Street, NW., Washington, DC 20549. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying at the Commission's Public Reference Section 450 Fifth Street, NW., Washington, DC 20549. Copies of such filing will also be available for inspection and copying at

the principal office of the PSE. All submissions should refer to File No. SR-PSE-91-37 and should be submitted by December 6, 1991.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 91-28263 Filed 11-22-91; 8:45 am]

BILLING CODE 8010-01-M

Self-Regulatory Organizations; Applications for Unlisted Trading Privileges and of Opportunity for Hearing; Philadelphia Stock Exchange, Inc.

November 19, 1991.

The above named national securities exchange has filed applications with the Securities and Exchange Commission ("Commission") pursuant to section 12(f)(1)(B) of the Securities Exchange Act of 1934 and Rule 12f-1 thereunder for unlisted trading privileges in the following securities:

Amphenol Corporation
Class A Common Stock, \$.001 Par Value
(File No. 7-7553)
Sears Roebuck & Co.
Depository Shares, \$1 Par Value (File No. 7-7554)
Total
American Depository Shares (File No. 7-7555)

These securities are listed and registered on one or more other national securities exchange and are reported in the consolidated transaction reporting system.

Interested persons are invited to submit on or before December 11, 1991, written data, views and arguments concerning the above-referenced application. Persons desiring to make written comments should file three copies thereof with the Secretary of the Securities and Exchange Commission, 450 5th Street, NW., Washington, DC 20549. Following this opportunity for hearing, the Commission will approve the application if it finds, based upon all the information available to it, that the extensions of unlisted trading privileges pursuant to such applications are consistent with the maintenance of fair and orderly markets and the protection of investors.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

Jonathan G. Katz,

Secretary.

[FR Doc. 91-28268 Filed 11-22-91; 8:45 am]

BILLING CODE 8010-01-M

SMALL BUSINESS ADMINISTRATION

Reporting and Recordkeeping Requirements Under OMB Review

ACTION: Notice of reporting requirements submitted for review.

SUMMARY: Under the provisions of the Paperwork Reduction Act (44 U.S.C. Chapter 35), agencies are required to submit proposed reporting and recordkeeping requirements to OMB for review and approval, and to publish a notice in the *Federal Register* notifying the public that the agency has made such a submission.

DATES: Comments should be submitted on or before December 26, 1991. If you intend to comment but cannot prepare comments promptly, please advise the OMB Reviewer and the Agency Clearance Officer before the deadline.

COPIES: Request for clearance (S.F. 83), supporting statement, and other documents submitted to OMB for review may be obtained from the Agency Clearance Officer. Submit comments to the Agency Clearance Officer and the OMB Reviewer.

FOR FURTHER INFORMATION CONTACT:

Agency Clearance Officer: Cleo Verbillis, Small Business Administration, 409 3rd Street, SW., 5th Floor, Washington, DC 20416, Telephone: (202) 205-6629.

OMB Reviewer: Gary Waxman, Office of Information and Regulatory Affairs, Office of Management and Budget, New Executive Office Building, Washington, DC 20503.

Title: 7(J) Client Service Report and Verification Form.

Form No.: SBA Forms 1538.

Frequency: On Occasion.

Description of Respondents: Minority Small Businesses.

Annual Responses: 2,000.

Annual Burden: 167.

Richard Sadowski,

Director, Office of Administrative Services.

[FR Doc. 91-28231 Filed 11-22-91; 8:45 am]

BILLING CODE 8025-01-M

DEPARTMENT OF STATE

Office of the Secretary

[Public Notice 1526]

Extension of the Restriction on the Use of the United States Passport for Travel To, In, or Through Libya

On December 11, 1981, pursuant to the authority of 22 U.S.C. 211a and Executive order 11295 (31 FR 10603), and

in accordance with 22 CFR 51.73(a)(3), the use of the United States passport for travel to, in, or through Libya was restricted. These restrictions have subsequently been extended on November 29, 1982 (47 FR 54888), November 29, 1983 (48 FR 55529), November 29, 1984 (49 FR 47585), November 25, 1985 (50 FR 49809), December 9, 1986 (51 FR 44855), December 10, 1987 (52 FR 46876), December 8, 1988 (53 FR 49633), December 7, 1989 (54 FR 50568) and November 30, 1990 (55 FR 49746). These actions were required by the unsettled relations between the United States and the Government of Libya and the threats of hostile acts against Americans in Libya.

The Government of Libya still maintains a decidedly anti-American stance and continues to emphasize its willingness to direct hostile acts against the United States and its nationals. The American Embassy in Tripoli remains closed, thus preventing the United States from providing routine diplomatic protection or consular assistance to Americans who may travel to Libya.

In light of these events and circumstances, I have determined that Libya continues to be an area " * * * where there is imminent danger to the public health or physical safety of United States travelers."

Accordingly, United States passports shall remain invalid for use in travel to, in, or through Libya unless specifically validated for such travel under the authority of the Secretary of State.

The Public Notice shall be effective upon publication in the *Federal Register* and shall expire at the end of one year unless sooner extended or revoked by Public Notice.

Dated: November 15, 1991.

Lawrence S. Eagleburger,
Acting Secretary of State.

[FR Doc. 91-28225 Filed 11-22-91; 8:45 am]

BILLING CODE 4710-06-M

DEPARTMENT OF TRANSPORTATION

Privacy Act of 1974: Systems of Records; Employee Transportation Facilitation

The Department of Transportation (DOT) herewith publishes a notice relating to the establishment of a new system of records maintained in connection with ridesharing, parking permit application files, vanpool application files, and transit fare subsidies within the Department of Transportation. The establishment of this new system of records will ensure better management and control of data,

and will delete the system of records DOT/OST 024, Parking Permit Application Files and Vanpool Application Files.

Any person or agency may submit written comments on the proposed system for Washington, DC to Chief, Transportation and Parking Section (M-443.3), Office of the Secretary, Department of Transportation, 400 Seventh Street SW., Washington, DC 20590. Comments for field installations should be addressed to the chief administrative officer at each installation.

Comments to be considered must be received by December 18, 1991. If no comments are received, the proposed system will become effective on the above-mentioned date. If comments are received, the comments will be considered and where adopted, the document will be republished with the changes.

Issued in Washington, DC November 18, 1991.

Melissa J. Allen,

Deputy Assistant Secretary for Administration.

DOT/ALL-8

SYSTEM NAME:

Employee Transportation Facilitation.

SYSTEM LOCATION:

For Washington DC.: Department of Transportation, Office of the Secretary (OST), Parking Management Office, M-443.3, 400 Seventh Street, SW., Room 2217, Washington, DC 20590.

SYSTEM LOCATIONS:

For field installations: See the chief administrative officer at each installation.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

- Holders of parking permits and members of carpools and vanpools.
- Applicants for ridesharing information.
- Recipients of match letters for carpooling.
- Applicants and recipients of fare subsidies issued by DOT.

CATEGORIES OF RECORDS IN THE SYSTEM:

- Records of holders of parking permits and records of carpool and vanpool members.
- Records and reports of status of rideshare applications.
- Copies of applications and match letters received by rideshare applicants.
- Applications and certifications of fare subsidy recipients.

- Records and reports of disbursements to fare subsidy recipients.

- Information on local public mass transit facilities and fare subsidy programs.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

- Carpool listing produced for use in creating or enlarging carpools or vanpools.
- Used for production of listings and reports.
- Used for administrative purposes by parking management and fare subsidy management.
- Used for periodic review or revalidation.
- Used as part of a program designed to ensure eligibility for, and receipt of, fare subsidy.
- See Prefatory Statement of General Routine Uses.

DISCLOSURES TO CONSUMER REPORTING AGENCIES:

Disclosures pursuant to 5 U.S.C. 552a(b)(12). Disclosures may be made from this system to consumer reporting agencies (collecting on behalf of the U.S. Government) as defined in the Fair Credit Reporting Act (15 U.S.C. 1681a(f)) or the Federal Claims Collection Act of 1982 (31 U.S.C. 3701(a)(3)).

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM: STORAGE:

Records are stored in hard copy or electronically, depending on the number of entries at each installation. Storage is at the geographic location of the servicing office.

RETRIEVABILITY:

Records can be retrieved by name or by ZIP code of residence.

SAFEGUARDS:

Except for carpool listings, access is accorded only to parking and fare subsidy management offices. Printout of carpool listing used in matching program has name, agency, DOT permit number, and work telephone number only and is available upon request.

RETENTION AND DISPOSAL:

- Data are deleted and not retained on ADP once the individual leaves the system for any reason (i.e., is no longer on the ridesharing listing, is no longer a member of a carpool or vanpool, or no longer receives a fare subsidy).
- Record copies of monthly reports and listings are retained at each installation, headquarters and field, for

three years, forwarded to the Federal Records Center for two more years, and then destroyed.

- Consolidated reports of all installations are retained at headquarters for three years, forwarded to the Federal Records Center for two more years, and then destroyed.

SYSTEM MANAGER AND ADDRESS:

For Washington DC.: Chief, Transportation and Parking Section, M443.3, U.S. Department of Transportation, Office of the Secretary, 400 Seventh Street, SW., Room 2217, Washington, DC 20590.

SYSTEM MANAGERS AND ADDRESSES

For field installations: See the chief administrative officer at each installation.

Notification procedures: Individual may review own data upon presentation of valid DOT ID card. For Washington, D.C. Headquarters buildings, see System Manager. For field installations, see chief administrative officer at each installation.

RECORD ACCESS PROCEDURES:

Same as Notification Procedure.

CONTESTING RECORD PROCEDURES:

Same as Notification Procedure.

RECORD SOURCE CATEGORIES:

Information in this system of records is obtained from applications submitted by individuals for parking permits, carpool and vanpool membership, ridesharing information, and fare subsidies; from notifications from other Federal agencies in the program; and from periodic certifications and reports regarding fare subsidies.

Narrative Statement for Department of Transportation

Office of the Secretary

The Office of the Secretary of Transportation (OST), proposes to establish a new system of records, "Employee Transportation Facilitation" DOT/ALL-6 to be established under the Privacy Act of 1974. This system contains information on individuals applying for ridesharing information, parking permits, vanpool permits, and transit fare subsidies.

The purpose of this notice is to establish the system and include, as a routine use of the information contained in the system, matching of applicants for the purpose of creating or adding to carpools and vanpools and the distribution of information concerning applications by individuals to other Federal agencies as part of a matching program designed to expose fraudulent

applications. Under certain circumstances the release of this information to other Federal agencies will create a valuable deterrent effect on individuals fraudulently appearing on more than one carpool or vanpool application and/or requesting a fare subsidy. This will give Parking Management Offices information they need to help prevent carpool and vanpool permits or fare subsidies being issued to individuals that do not meet the requirements.

The authority to maintain this system of records is contained in Section 629, Treasury, Postal Service, and General Government Appropriations Act, 1991 (Public Law 101-509; November 5, 1990).

Most of the information in the system is provided voluntarily by individuals filling out applications which have a Privacy Act Disclosure printed on them. The information will be used in accordance with the stated routine uses and will not unduly impact individual privacy rights.

Information in this system may be processed in both hard copy and computerized environments. A description of the steps taken to safeguard these records is given under the appropriate heading in the attached copy of the system notice for the system prepared for publication in the Federal Register.

The purpose of this report is to comply with Office of Management and Budget Circular A-130, Appendix 1, "Federal Agency Responsibilities for Maintaining Records About Individuals," dated December 12, 1985.

[FR Doc. 91-28206 Filed 11-22-91; 8:45 am]

BILLING CODE 4910-62-M

[(Order 91-11-15) Dockets 47504 and 47505]

Applications of HCL Aviation, Inc., d/b/a AV Atlantic For Certificate Authority

AGENCY: Department of Transportation.

ACTION: Notice of order to show cause.

SUMMARY: The Department of Transportation is directing all interested persons to show cause why it should not issue orders finding HCL Aviation, Inc. d/b/a Av Atlantic fit, willing, and able, and awarding it certificates of public convenience and necessity to engage in domestic and foreign charter air transportation of persons, property, and mail.

DATES: Persons wishing to file objections should do so no later than November 30, 1991.

ADDRESSES: Objections and answers to objections should be filed in Dockets 47504 and 47505 and addressed to the Documentary Services Division (C-55, room 4107), U.S. Department of Transportation, 400 Seventh Street, SW., Washington, D.C. 20590 and should be served upon the parties listed in Attachment A to the order.

FOR FURTHER INFORMATION CONTACT:

Ms. Delores King, Air Carrier Fitness Division (P-56, room 6401), U.S. Department of Transportation, 400 Seventh Street, SW., Washington, DC 20590, (202)366-2343.

Dated: November 15, 1991.

Jeffrey N. Shane,

Assistant Secretary for Policy and International Affairs.

[FR Doc. 91-28204 Filed 11-22-91; 8:45 am]

BILLING CODE 4910-62-M

Aviation Proceedings; Agreements Filed During the Week Ended November 15, 1991

The following Agreements were filed with the Department of Transportation under the provisions of 49 U.S.C. 412 and 414. Answers may be filed within 21 days of date of filing.

Docket Number: 47838.

Date filed: November 14, 1991.

Parties: Members of the International Air Transport Association.

Subject: TC23/TC123 Reso/C 010NN (amending India-Germany Cargo Rate Structure).

Proposed Effective Date: December 1, 1991.

Phyllis T. Kaylor,

Chief, Documentary Services Division.

[FR Doc. 91-28202 Filed 11-22-91; 8:45 am]

BILLING CODE 4910-62-M

Notice of Applications for Certificates of Public Convenience and Necessity and Foreign Air Carrier Permits Filed Under Subpart Q During the Week Ended November 15, 1991

The following Applications for Certificates of Public Convenience and Necessity and Foreign Air Carrier Permits were filed under subpart Q of the Department of Transportation's Procedural Regulations (See 14 CFR 302.1701 *et. seq.*). The due date for Answers, Conforming Applications, or Motions to Modify Scope are set forth below for each application. Following the Answer period DOT may process the application by expedited procedures. Such procedures may consist of the adoption of a show-cause order, a

tentative order, or in appropriate cases a final order without further proceedings.

Docket Number: 47835.

Date filed: November 12, 1991.

Due Date for Answers, Conforming Applications, or Motion to Modify Scope: December 10, 1991.

Description: Application of Cayman Airways Limited, pursuant to section 402 of the Act and subpart Q of the Regulations applies for an amendment of its foreign air carrier permit so as to authorize CAL to serve a sixth U.S. point, Baltimore, Maryland.

Docket Number: 47840.

Date filed: November 15, 1991.

Due Date for Answers, Conforming Applications, or Motion to Modify Scope: December 13, 1991.

Description: Application of Alaska Airlines, Inc., pursuant to section 401 of the Act and Subpart Q of the Regulations requests a certificate of public convenience and necessity to operate scheduled service in foreign air transportation for passengers, property and mail between Anchorage, Alaska, on the one hand, and Vladivostok, U.S.S.R., on the other hand.

Docket Number: 47842.

Date filed: November 15, 1991.

Due Date for Answers, Conforming Applications, or Motion to Modify Scope: December 13, 1991.

Description: Application of Pegasus International Inc., pursuant to section 401(d)(1) of the Act and subpart Q of the Regulations for issuance of a Certificate of Public Convenience and Necessity to provide foreign air transportation of persons, property and mail between various points in the United States, on the one hand, and points in South Africa, on the other hand.

Phyllis T. Kaylor,

Chief, Documentary Services Division.

[FR Doc. 91-28203 Filed 11-22-91; 8:45 am]

BILLING CODE 4910-62-M

Federal Aviation Administration

Noise Exposure Map Notice; Receipt of Noise Compatibility Program and Request for Review; Huntsville International Airport; Huntsville, AL

AGENCY: Federal Aviation Administration, DOT.

ACTION: Notice.

SUMMARY: The Federal Aviation Administration (FAA) announces its determination that the noise exposure maps submitted by the Huntsville-Madison County Airport Authority for Huntsville International Airport, under the provisions of title I of the Aviation Safety and Noise Abatement Act of 1979

(Pub. L. 96-193) and 14 CFR part 150 are in compliance with applicable requirements. The FAA also announces that it is reviewing a proposed noise compatibility program that was submitted for Huntsville International Airport under part 150 in conjunction with the noise exposure map, and that this program will be approved or disapproved on or before May 12, 1992.

EFFECTIVE DATE: The effective date of the FAA's determination on the noise exposure maps and of the start of its review of the associated noise compatibility program is November 14, 1991. The public comment period ends January 13, 1992.

FOR FURTHER INFORMATION CONTACT: Wayne Atkinson, Assistant Manager Jackson Airports District Office, 120 North Hangar Drive, suite B, Jackson, Mississippi 39208-2306; telephone no. (601) 965-4628. Comments on the proposed noise compatibility program should also be submitted to this address.

SUPPLEMENTARY INFORMATION: This notice announces that the FAA finds that the noise exposure maps submitted for Huntsville International Airport are in compliance with applicable requirements of part 150, effective November 14, 1991. Further, FAA is reviewing a proposed noise compatibility program for that airport which will be approved or disapproved on or before May 12, 1992. This notice also announces the availability of this program for public review and comment.

Under section 103 of title I of the Aviation Safety and Noise Abatement Act of 1979 (hereinafter referred to as "the Act"), an airport operator may submit to the FAA noise exposure maps which meet applicable regulations and which depict noncompatible land uses as of the date of submission of such maps, a description of projected aircraft operations, and the ways in which such operations will affect such maps. The Act requires such maps to be developed in consultation with interested and affected parties in the local community, government agencies and persons using the airport.

An airport operator who has submitted noise exposure maps that are found by FAA to be in compliance with the requirements of Federal Aviation Regulations (FAR) part 150, promulgated pursuant to title I of the Act, may submit a noise compatibility program for FAA approval which sets forth the measures the operator has taken or proposes for the reduction of existing noncompatible uses and for the prevention of the introduction of additional noncompatible uses.

The Huntsville-Madison County Authority submitted to the FAA on June 28, 1991, noise exposure maps, descriptions and other documentation which were produced during the period from October 1, 1988, to date. It was requested that the FAA review this material as the noise exposure maps, as described in section 103(a)(1) of the Act, and that the noise mitigation measures, to be implemented jointly by the airport and the surrounding communities, be approved as a noise compatibility program under section 104(b) of the Act.

The FAA has completed its review of the noise exposure maps and related descriptions submitted by the Huntsville-Madison County Airport Authority. The specific maps under consideration are "Exhibit 4-2, 1988 Ldn Noise Exposure Map" (with accompanying certification that this map accurately reflects the 1990 conditions), and "Exhibit 4-3, 1993 Ldn Noise Exposure Map With Passenger and All-Cargo Hubbing" (with accompanying certification that this map accurately reflects the 1995 conditions) in Chapter Four (4) of the report entitled "Final Report; FAR part 150 Noise Exposure Maps and Noise Compatibility Program Update, Huntsville International Airport; Prepared for Huntsville-Madison County Airport Authority, Huntsville, Alabama; June 1991. The FAA has determined that these maps for Huntsville International Airport are in compliance with applicable requirements. This determination is effective on November 14, 1991. FAA's determination on an airport operator's noise exposure maps is limited to finding that the maps were developed in accordance with the procedure contained in appendix A of FAR part 150. Such determination does not constitute approval of the applicant's data, information or plans, or a commitment to approve a noise compatibility program or to fund the implementation of that program.

If questions arise concerning the precise relationship of specific properties to noise exposure contours depicted on a noise exposure map submitted under section 103 of the Act, it should be noted that the FAA is not involved in any way in determining the relative locations of specific properties with regard to the depicted noise contours, or in interpreting the noise exposure maps to resolve questions concerning, for example, which properties should be covered by the provisions of section 107 of the Act. These functions are inseparable from the ultimate land-use control and planning responsibilities of local

government. These local responsibilities are not changed in any way under part 150 or through FAA's review of noise exposure maps. Therefore, the responsibility for the detailed overlaying of noise exposure contours onto the map depicting properties on the surface rests exclusively with the airport operator which submitted those maps, or with those public agencies and planning agencies with which consultation is required under section 103 of the Act. The FAA has relied on the certification by the airport operator, under § 150.21 of FAR part 150, that the statutorily required consultation has been accomplished.

The FAA has formally received the noise compatibility program for Huntsville International Airport, also effective on June 23, 1991. Preliminary review of the submitted material indicates that it conforms to the requirements for the submittal of noise compatibility programs, but that further review will be necessary prior to approval or disapproval of the program. The formal review period, limited by law to a maximum of 180 days, will be completed on or before May 12, 1992.

The FAA's detailed evaluation will be conducted under the provisions of 14 CFR part 150, § 150.33. The primary considerations in the evaluation process are whether the proposed measures may reduce the level of aviation safety, create an undue burden on interstate or foreign commerce, or be reasonably consistent with obtaining the goal of reducing existing noncompatible land uses and preventing the introduction of additional noncompatible land uses.

Interested persons are invited to comment on the proposed program with specific reference to these factors. All comments, other than those properly addressed to local land-use authorities, will be considered by the FAA to the extent practicable. Copies of the noise exposure maps, the FAA's evaluation of the maps and the proposed noise compatibility program are available for examination at the following locations:

Airports District Office, 120 North
Hangar Drive, suite B, Jackson,
Mississippi 39208-2306.
Huntsville-Madison County Airport
Authority, 1000 Glenn Hearn Blvd.,
Box 20008, Huntsville, Alabama 35824.

Questions may be directed to the individual named above under the

heading. **FOR FURTHER INFORMATION CONTACT.**

Issued in Jackson, Mississippi, November 14, 1991.

Charles E. Blair,

Manager, Airports District Office.

[FR Doc. 91-28307 Filed 11-22-91; 8:45 am]

BILLING CODE 4910-13-M

Radio Technical Commission for Aeronautics (RTCA); Special Committee 162; Aviation Systems Design Guidelines for Open Systems Interconnection (OSI); Meeting

Pursuant to section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92-463, 5 U.S.C., appendix I), notice is hereby given for the sixteenth meeting of Special Committee 162 to be held December 4-6, 1991, in the RTCA conference room, 1140 Connecticut Avenue, NW., suite 1020, Washington, DC 20036, commencing at 9:30 a.m.

The agenda for this meeting is as follows: (1) Chairman's introductory remarks; (2) Approval of minutes of the fifteenth meeting held July 24-26, 1991, RTCA paper no. 499-91/SC162-126 (previously distributed); (3) Reports of related activities being conducted by other organizations; (4) Review activities of the ATNI MASPS/MOPS Working Group; (5) Review draft of the Applications Guidance (Part 2) Document; (6) Review draft of the Applications Programming Interface (Part 3) Document; (7) Review status of Systems Security Guidance Document; (8) Review status of Systems Management Guidance Document; (9) Other business; (10) Date and place of next meeting.

Attendance is open to the interested public but limited to space available. With the approval of the Chairman, members of the public may present oral statements at the meeting. Persons wishing to present statements or obtain information should contact the RTCA Secretariat, 1140 Connecticut Avenue, NW., suite 1020, Washington, DC 20036; (202) 833-9339. Any member of the public may present a written statement to the committee at any time.

Issued in Washington, DC on November 12, 1991.

Joyce J. Gillen,

Designated Officer.

[FR Doc. 91-28309 Filed 11-22-91; 8:45 am]

BILLING CODE 4910-13-M

Radio Technical Commission for Aeronautics (RTCA); Special Committee 147; Minimum Operational Performance Standards for Traffic Alert and Collision Avoidance System Airborne Equipment; Meeting

Pursuant to section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92-463, 5 U.S.C., appendix I), notice is hereby given for the thirty-eighth meeting of Special Committee 147 to be held December 11-13, 1991, in the RTCA conference room 1140 Connecticut Avenue, NW., suite 1020, Washington, DC 20036, commencing at 9:30 a.m.

The agenda for this meeting is as follows: (1) Chairman's introductory remarks; (2) Review of meeting agenda; (3) Approval of minutes of the thirty-seventh meeting held on September 11-13, 1991, RTCA paper no. 321-91/SC147-466; (4) Reports of working group assignments; (a) Pilot working group/ Separation Assurance Task Force; (b) Requirements Working Group; (5) FAA TCAS Program Office report; (6) Review of plans for end-to-end verification and validation process; (7) Review of EUROCAE Working Group 34 activities; (8) Review of action items from last meeting; (a) SC-147 Change Review Board Progress (K. Ybarra, Honeywell); (b) Report on High Level Requirements for Displays (G. Lyddane, FAA); (c) Letter to FAA requesting contractor support for verification and validation process; (d) Validation of CAS Logic Decisions (U. Satyen, MITRE); (e) Review of SAE letter to SC-147 (MITRE); (f) Report on Mode S configuration issue coordination (R. Bowers, ATA); (9) Discussion of advanced TCAS concepts; (10) Other business; (11) Date and place of next meeting.

Attendance is open to the interested public but limited to space available. With the approval of the Chairman, members of the public may present oral statements at the meeting. Persons wishing to present statements or obtain information should contact the RTCA Secretariat, 1140 Connecticut Avenue, NW., suite 1020, Washington, DC 20036; (202) 833-9339. Any member of the public may present a written statement to the committee at any time.

Issued in Washington, DC, on November 12, 1991.

Joyce J. Gillen,
Designated Officer.

[FR Doc. 91-28310 Filed 11-22-91; 8:45 am]

BILLING CODE 4910-13-M

Radio Technical Commission for Aeronautics (RTCA), Special Committee 163; Unintentional or Simultaneous Transmissions That Adversely Affect Two-Way Radio Communication; Meeting

Pursuant to section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92-463, 5 U.S.C., appendix I), notice is hereby given for the twelfth meeting of Special Committee 163 to be held December 16-18, 1991, in the RTCA conference room, 1140 Connecticut Avenue, NW., suite 1020, Washington, DC 20036, commencing at 9:30 a.m.

The agenda for this meeting is as follows: (1) Chairman's introductory remarks; (2) Approval of the eleventh meeting's minutes, RTCA paper no. 350-90/SC163-119; (3) Compare EUROCAE WG-38 draft MOPS to SC-163 draft MOPS and develop final draft; (4) Review data submitted by FAA, Transport Canada, Manufacturers and other new information, with regard to impact on results of Appendix A; (5) Other business; (6) Date and place of next meeting, if required.

Attendance is open to the interested public but limited to space available. With the approval of the Chairman, members of the public may present oral statements at the meeting. Persons wishing to present statements or obtain information should contact the RTCA Secretariat, 1140 Connecticut Avenue, NW., suite 1020, Washington, DC 20036; (202) 833-9339. Any member of the public may present a written statement to the committee at any time.

Issued in Washington, DC, on November 12, 1991.

Joyce J. Gillen,
Designated Officer.

[FR Doc. 91-28311 Filed 11-22-91; 8:45 am]

BILLING CODE 4910-13-M

Aviation Rulemaking Advisory Committee; General Aviation Operations Subcommittee; Meeting

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of meeting.

SUMMARY: The FAA is issuing this notice to advise the public of a meeting of the Federal Aviation Administration General Aviation Operations Subcommittee of the Aviation Rulemaking Advisory Committee.

DATES: The meeting will be held on December 9, 1991, at 10 a.m.

ADDRESSES: The meeting will be held at Helicopter Association International, 1619 Duke Street, Alexandria, VA.

FOR FURTHER INFORMATION CONTACT:

Mr. Ron Myres, Executive Director,
General Aviation Operations
Subcommittee, Flight Standards Service
(AFS-850), 800 Independence Avenue,
SW., Washington, DC 20591, Telephone:
(202) 267-8150; FAX: (202) 267-5230.

SUPPLEMENTARY INFORMATION: Pursuant to section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92-463; 5 U.S.C. App. II), notice is hereby given of a meeting of the General Aviation Operations Subcommittee to be held on December 9, 1991, at the Helicopter Association International, 1619 Duke Street, Alexandria, VA. The agenda for this meeting will include progress reports from the IFR Fuel Reserve, Definition of Emergencies, and Operations over the High Seas Working Groups. In addition, the Minimum Safe Operating Altitude and Experimental/Restricted Category Operations Working Groups tentatively plan to present their formal recommendations to the subcommittee.

Attendance is open to the interested public but may be limited to the spaces available. The public must make arrangements in advance to present oral statements at the meeting or may present written statements to the committee at any time. Arrangements may be made by contacting the person listed under the heading **FOR FURTHER INFORMATION CONTACT**.

Issued in Washington, DC, on November 18, 1991.

Ron Myres,

*Executive Director, General Aviation
Operations Subcommittee, Aviation
Rulemaking Advisory Committee.*

[FR Doc. 91-28312 Filed 11-22-91; 8:45 am]

BILLING CODE 4910-13-M

Savannah International Airport, Savannah, GA; Intent to Rule on Application

AGENCY: Federal Aviation
Administration, DOT.

ACTION: Notice of Intent to Rule on
Application to Impose and Use the
Revenue From a Passenger Facility
Charge (PFC) at Savannah International
Airport, Savannah, Georgia.

SUMMARY: The Federal Aviation
Administration (FAA) proposes to rule
and invites public comment on the
application to impose and use the
revenue from a PFC at Savannah
International Airport under the
provisions of the Aviation Safety and
Capacity Expansion Act of 1990 (title IX
of the Omnibus Budget Reconciliation
Act of 1990) (Public Law 101-508) and 14
CFR part 158.

On October 18, 1991, the FAA
determined that the application to
impose and use the revenue from a PFC
submitted by the Savannah Airport
Commission was substantially complete
within the requirements of section 158.25
of Part 158. The FAA will approve or
disapprove the application, in whole or
in part, no later than January 23, 1991.

DATES: Comments must be received on
or before December 26, 1991.

ADDRESSES: Comments on this
application may be mailed or delivered
in triplicate to the FAA at the following
address:

DOT/FAA/Atlanta Airports District
Office, 1680 Phoenix Parkway, College
Park, Georgia 30349.

In addition, one copy of any
comments submitted to the FAA must
be mailed or delivered to Mr. Eldon E.
Davidson, Executive Director of the
Savannah Airport Commission, at the
following address:

Savannah International Airport, P.O.
Box 2723, Savannah, Georgia 31402-
2723.

Comments from air carriers and
foreign air carriers may be in the same
form as provided to the Savannah
Airport Commission under section
158.33 of Part 158.

FOR FURTHER INFORMATION CONTACT:
Catherine M. Nelmes, Program Manager,
DOT/FAA/Atlanta Airports District
Office, 1680 Phoenix Parkway, College
Park, Georgia 30349, telephone number
(404) 994-5306. The application may be
reviewed in person at this same
location.

SUPPLEMENTARY INFORMATION: The
following is a brief overview of the
application.

Level of the proposed PFC: \$3.00
Proposed charge effective date: July 1,
1992

Proposed charge expiration date: June
30, 2017

Total estimated PFC revenue:
\$110,098,800.00

Brief description of proposed projects:
passenger terminal building, terminal
apron and associated taxiways, I-95
interchange and entrance road, service
road, site work for development area,
utilities for development area.

Availability of application: Any
person may inspect the application in
person at the FAA office listed above. In
addition, any person may, upon request,
inspect the application, notice and other
documents germane to the application in
person at the Savannah Airport
Commission, Savannah International
Airport, Savannah, Georgia, telephone
number (912) 964-0514.

Issued in Atlanta, Georgia, on October 30, 1991.

Mr. Stephen A. Brill,
Manager, Airports Division Southern Region.
[FR Doc. 91-28308 Filed 11-22-91; 8:45 am]
BILLING CODE 4910-13-M

Federal Highway Administration

Environmental Impact Statement; Livingston County, MI

AGENCY: Federal Highway
Administration (FHWA), DOT.

ACTION: Notice of intent.

SUMMARY: The FHWA is issuing this notice to advise the public that a Tier 1 Environmental Impact Statement (EIS) will be prepared for the preservation of a 300 foot corridor along M-59 from I-96 to US-23 in Howell, Ocoola, and Hartland Townships, Livingston County, Michigan. The corridor will be preserved for possible future improvements to M-59 should they become necessary. A Tier 2 EIS will be prepared for the construction phase of the project.

FOR FURTHER INFORMATION CONTACT: Mr. Thomas A. Fort, District Engineer, Federal Highway Administration, 315 W. Allegan Street, Lansing, Michigan 48933 (FTS) 374-1879 or (Commercial) (517) 377-1879 or Mr. Paul W. McAllister, Project Coordination Unit, Bureau of Transportation Planning, P.O. Box 30050, Lansing, Michigan 48909, Telephone (517) 335-2622.

SUPPLEMENTARY INFORMATION: The FHWA, in cooperation with the Michigan Department of Transportation (MDOT), is preparing a Tier 1 Draft EIS for the preservation of a 300 foot corridor along M-59 from I-96 to US-23 in Howell, Ocoola and Hartland Townships, Livingston County, Michigan. The corridor is approximately 12.6 miles long. Preservation is needed to protect the corridor from possible future development and to retain the ability to expand M-59 along the existing highway. Part of the area along M-59 is currently under intense development pressure. It is anticipated that the area will be developed and traffic will be increased to the point where improvements are needed. The M-59 corridor is the most logical location for future transportation improvements should they become necessary, and this corridor should have less environmental impact than a new route on new location. Should extensive development occur within the proposed corridor, real estate costs and other social and economic impacts could prohibit the future use of this corridor

for highway improvements if it is not preserved.

A Tier 2 EIS will be prepared for the construction phase of the project. The preparation of a Tier 1 EIS will not preclude the development of other alternatives at the construction phase, nor does it necessitate the possible future improvements. The right-of-way can be resold or released should it be determined that future improvements are no longer a possibility. The no action alternative will be considered in the Tier 1 EIS, as well as in the Tier 2 EIS.

The current facility is two lanes, and for most of its length is within 120 feet of right-of-way. An additional 180 feet of right-of-way is necessary. The proposed corridor follows the existing facility. The corridor generally stays on either the north or south side of the existing highway in order to minimize real estate impacts. The corridor moves from one side of the road to another to avoid sensitive environmental areas or already developed areas.

Letters describing the proposed action and soliciting comments have been sent to appropriate federal, state, and local agencies, with information describing this proposal attached. Letters have also been sent to organizations who are known to have an interest in this proposal to provide them the opportunity to comment. A public information meeting was held on June 19, 1991, to provide the public the opportunity to discuss the proposed action. A public hearing will also be held. Public notice will be given of the time and place of the hearing. The Tier 1 Draft EIS will be available for public and agency review and comment prior to the public hearing. No formal scoping meeting or scoping document is planned at this time.

To ensure that the full range of issues related to this proposal are addressed and all significant issues identified, comments, and suggestions are invited from all interested parties. Comments or questions concerning this proposed action and the EIS should be directed to the FHWA at the address provided above.

(Catalog of Federal Domestic Assistance Program Number 20.205, Highway Research, Planning and Construction. The provisions of OMB Circular No. A-95 regarding state and local clearinghouse review of federal and federally assisted programs and projects apply to this program)

A. George Ostensen,
Division Administrator, Lansing, Michigan.
[FR Doc. 91-28712 Filed 11-22-91; 8:45 am]

BILLING CODE 4910-22-M

DEPARTMENT OF THE TREASURY**Public Information Collection Requirements Submitted to OMB for Review**

Date: November 19, 1991.

The Department of Treasury has made revisions and resubmitted the following public information collection requirement(s) to OMB for review and clearance under the Paperwork Reduction Act of 1980, Public Law 96-511. Copies of the submission(s) may be obtained by calling the Treasury Bureau Clearance Officer listed. Comments regarding this information collection should be addressed to the OMB reviewer listed and to the Treasury Department Clearance Officer, Department of the Treasury, room 3171 Treasury Annex, 1500 Pennsylvania Avenue, NW., Washington, DC 20220.

Internal Revenue Service

OMB Number: 1545-0028.

Form Number: IRS Forms 940 and 940PR.

Type of Review: Resubmission.

Title: Employer's Annual Federal Unemployment (FUTA) Tax Return (940); Planilla Para La Declaracion Anual Del Patrono * * * La Contribucion Federal Para El Desempleo (FUTA) (940PR).

Description: Internal Revenue Code (IRC) section 3301 imposes a tax on employers based on the first \$7,000 of taxable annual wages paid to each employee. IRS uses the information reported on Forms 940 and 940PR (Puerto Rico) to ensure that employers have reported and figured the correct FUTA wages and tax.

Respondents: Individuals or households, Farms, Businesses or other for-profit, Small businesses or organizations.

Estimated Number of Respondents/Recordkeepers: 4,385,470.

Estimated Burden Hours Per Respondent/Recordkeeper:
Recordkeeping—14 hours, 21 minutes;
Learning about the law or the form—12 minutes;
Preparing and sending the form to IRS—26 minutes.

Frequency of Response: Annually
Estimated Total Reporting/Recordkeeping Burden: 65,678,345 hours
Clearance Officer: Garrick Shear (202) 535-4297, Internal Revenue Service, room 5571, 1111 Constitution Avenue, NW., Washington, DC 20224.

OMB Reviewer: Milo Sunderhauf (202) 395-6880, Office of Management and Budget, room 3001, New Executive Office Building, Washington, DC 20503.

Lois K. Holland,
Departmental Reports Management Officer.

[FR Doc. 91-28199 Filed 11-22-91; 8:45 am]

BILLING CODE 4830-01-M

Public Information Collection Requirements Submitted to OMB for Review

Date: November 14, 1991.

The Department of Treasury has submitted the following public information collection requirement(s) to OMB for review and clearance under the Paperwork Reduction Act of 1980, Public Law 96-511. Copies of the submission(s) may be obtained by calling the Treasury Bureau Clearance Officer listed. Comments regarding this information collection should be addressed to the OMB reviewer listed and to the Treasury Department Clearance Officer, Department of the Treasury, room 3171 Treasury Annex, 1500 Pennsylvania Avenue, NW., Washington, DC 20220.

Internal Revenue Service

OMB Number: 1545-0946.

Form Number: IRS Forms 8554 and 8498.

Type of Review: Extension.

Title: Application for Renewal of Enrollment to Practice Before the Internal Revenue Service (8554) Program Sponsor Agreement for Continuing Professional Education for Enrolled Agents (8498).

Description: This information relates to the approval of continuing professional education programs and the renewal of enrollment status for those individuals admitted (enrolled) by the Internal Revenue Service.

Respondents: Individuals or households.

Estimated Number of Respondents/Recordkeepers: 30,500.

Estimated Burden Hours Per

Respondent/Recordkeeper: 36 minutes.

Frequency of Response: Other (One-time filing).

Estimated Total Reporting/Recordkeeping Burden: 36,600 hours.

OMB Number: 1545-0949.

Form Number: IRS Form 2587.

Type of Review: Extension.

Title: Application for Special Enrollment Examination.

Description: This information relates to the determination of the eligibility of individuals seeking enrollment status to practice before the Internal Revenue Service.

Respondents: Individuals or households.

Estimated Number of Respondents: 8,000.

Estimated Burden Hours Per Respondent: 6 minutes.

Frequency of Response: Other (One-time filing).

Estimated Total Reporting Burden: 800 hours.

Clearance Officer: Garrick Shear (202) 535-4297, Internal Revenue Service, room 5571, 1111 Constitution Avenue, NW., Washington, DC 20224.

OMB Reviewer: Milo Sunderhauf (202) 395-6680, Office of Management and Budget, room 3001, New Executive Office Building, Washington, DC 20503.

Lois K. Holland,

Departmental Reports Management Officer.

[FR Doc. 91-28201 Filed 11-22-91; 8:45 am]

BILLING CODE 4930-01-M

Sunshine Act Meetings

Federal Register

Vol. 56, No. 227

Monday, November 25, 1991

This section of the FEDERAL REGISTER contains notices of meetings published under the "Government in the Sunshine Act" (Pub. L. 94-409) 5 U.S.C. 552b(e)(3).

DEPARTMENT OF ENERGY FEDERAL ENERGY REGULATORY COMMISSION

Notice

November 20, 1991.

The following notice of meeting is published pursuant to Section 3(a) of the Government in the Sunshine Act (Pub. L. No. 94-409), 5 U.S.C. 552b:

DATE AND TIME: November 27, 1991, 10:00 a.m.

PLACE: 825 North Capitol Street, N.E., Room 9306, Washington, D.C. 20426.

STATUS: Open.

MATTERS TO BE CONSIDERED: Agenda.

Note.—Items listed on the agenda may be deleted without further notice.

CONTACT PERSON FOR MORE

INFORMATION: Lois D. Cashell, Secretary, Telephone (202) 208-0400. For a recording listing items stricken from or added to the meeting, call (202) 208-1627.

This is a list of matters to be considered by the Commission. It does not include a listing of all papers relevant to the items on the agenda; however, all public documents may be examined in the Reference and Information Center.

Consent Agenda—Hydro, 948th Meeting—November 27, 1991, Regular Meeting (10:00 a.m.)

CAH-1.

Project No. 10674-004, Midtec Paper Corporation

CAH-2.

Project No. 10725-001, Little Horn Energy Wyoming, Inc.

CAH-3.

Docket No. EL88-25-001, Iliamna-Newhalen-Nondalton Electric Cooperative, Inc.

CAH-4.

Project No. 516-093, Lake Murray Docks v. South Carolina Electric & Gas Company

CAH-5.

Project No. 4636-008, Fourth Branch Associates

CAH-6.

Project Nos. 2067-004 and 005, Oakdale and South San Joaquin Irrigation Districts

CAH-7.

Project No. 9085-002, Richard Balagur

Consent Agenda—Electric

CAE-1.

Docket Nos. ER91-570-001, ER91-150-004, EL91-29-001 and ER91-236-001, Southern Company Services, Inc.

Docket No. EL91-14-000, Cajun Electric Power Cooperative, Inc.

CAE-2.

Docket Nos. EC91-9-002, EL91-22-002 and ES91-21-002, UtiliCorp United, Inc. and Centel Corporation

CAE-3.

Docket No. ER86-562-001, Boston Edison Company

CAE-4.

Docket No. EL91-36-000, Massachusetts Municipal Wholesale Electric Company v. Northeast Utilities Service Company

CAE-5.

Docket No. EL91-53-000, Town of Norwood Massachusetts v. New England Power Company

Docket Nos. ER91-565-000 and ER91-566-000, New England Power Company

CAE-6.

Docket No. EL91-48-000, American Municipal Power-Ohio, Inc. and the City of Cuyahoga Falls, Ohio v. Ohio Edison Company

CAE-7.

Docket No. EL91-2-000, Northern States Power company (Minnesota) and Northern States Power Company (Wisconsin)

CAE-8.

Docket No. EL79-8-000, Central Power and Light Company, Public Service Company of Oklahoma, Southwestern Electric Power Company and West Texas Utilities Company

CAE-9.

Docket No. ER91-300-000, Montaup Electric Company

CAE-10.

Docket No. ER91-322-000, Pennsylvania Power & Light Company

CAE-11.

Docket No. ER84-560-032, Union Electric Company

Consent Agenda—Oil and Gas

CAG-1.

Docket No. RP92-21-000, Williams Natural Gas Company

CAG-2.

Docket No. RP92-19-000, Transwestern Pipeline Company

CAG-3.

Docket No. RP92-17-000, CNG Transmission Corporation

CAG-4.

Docket No. RP91-210-002, Tennessee Gas Pipeline Company

CAG-5.

Docket No. TQ92-1-55-000, Questar Pipeline Company

CAG-6.

- Docket Nos. IS92-2-000, IS91-24-000 and IS91-30-000, Tecumseh Pipe Line Company
- CAG-7.
Docket No. RP92-16-000, El Paso Natural Gas Company
- CAG-8.
Docket No. RP92-18-000, El Paso Natural Gas Company
- CAG-9.
Docket No. RP92-24-000, Natural Gas Pipeline Company of America
- CAG-10.
Docket Nos. TF92-1-20-000 and TM92-5-20-000, Algonquin Gas Transmission Company
- CAG-11.
Docket Nos. TA92-1-53-000 and 001, K N Energy, Inc.
- CAG-12.
Docket No. TQ92-3-4-000, Granite State Gas Transmission, Inc.
- CAG-13.
Docket Nos. TQ92-1-22-000 and RP90-143-007, CNG Transmission Corporation
- CAG-14.
Docket No. TQ92-3-25-000, Mississippi River Transmission Corporation
- CAG-15.
Docket No. TQ92-3-59-000, Northern Natural Gas Company
- CAG-16.
Docket No. TM92-5-21-000, Columbia Gas Transmission Corporation
- CAG-17.
Docket No. TM92-3-43-000, Williams Natural Gas Company
- CAG-18.
Docket No. RP89-185-008, Panhandle Eastern Pipe Line Company
- CAG-19.
Omitted
- CAG-20.
Docket Nos. RP85-203-007 and RP88-203-006, Panhandle Eastern Pipeline Company
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Docket No. RM92-1-000, Revisions to Uniform Systems of Accounts to Account for Allowances under the Clean Air Act Amendments of 1990 and Regulatory-Created Assets and Liabilities, and to Form Nos. 1, 1-F, 2 and 2-A. Notice of proposed rulemaking.

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Reserved

Lois D. Cashell,

Secretary.

[FR Doc. 91-28422 Filed 11-21-91; 3:47 am]

BILLING CODE 6717-01-M

Corrections

Federal Register

Vol. 56, No. 227

Monday, November 25, 1991

This section of the FEDERAL REGISTER contains editorial corrections of previously published Presidential, Rule, Proposed Rule, and Notice documents. These corrections are prepared by the Office of the Federal Register. Agency prepared corrections are issued as signed documents and appear in the appropriate document categories elsewhere in the issue.

DEPARTMENT OF COMMERCE

National Institute of Standards and Technology

[Notice 2]

National Fire Codes; Request for Proposal for Revision of Standards

Correction

In notice document 91-2200 beginning on page 3450 in the issue of January 30, 1991, make the following correction:

On page 3451, in the first column, in the file line at the end of the document, "FR Doc. 91-2097" should read "FR Doc. 91-2200".

BILLING CODE 1505-01-D

DEPARTMENT OF ENERGY

Federal Energy Regulation Commission

[Docket No. TM92-1-13-000]

Gas Gathering Corporation; Proposed Changes in FERC Gas Tariff

Correction

In notice document 91-22130 beginning on page 46787 in the issue of Monday, September 16, 1991, make the following correction:

On page 46788, in the first column, in the file line at the end of the document, "FR Doc. 91-2130" should read "FR Doc. 91-22130".

BILLING CODE 1505-01-D

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Toxic Substances and Disease Registry

[ATSDR-43]

Availability of Draft Toxicological Profiles

Correction

In notice document 91-24957 beginning on page 52036, in the issue of Thursday, October 17, 1991, make the following corrections:

1. On the same page, in the second column, in the **DATES** paragraph, in the fourth line, "February 8, 1992." should read "February 18, 1992."
2. On the same page, in the third column, under **SUPPLEMENTARY INFORMATION**, in the first paragraph, in the sixth line from the bottom, "141280)" should read "41280)".

BILLING CODE 1505-01-D

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Toxic Substances and Disease Registry

[ATSDR-42]

Identification of Priority Data Needs for 38 Priority Hazardous Substances

Correction

In notice document 91-24956 beginning on page 52178 in the issue of Thursday, October 17, 1991, make the following corrections:

1. On page 52179, in the second column, in the last paragraph, in the first line, "amended as" should read "amended at".
2. On page 52182, in Table 1, under the heading Group A, under the entry Zinc, in the second line, "histopatholoi-" should read "histopathologi-".
3. On the same page, in Table 2, under the heading Substance, in the last line, "DOE" should read "DDE".

BILLING CODE 1505-01-D

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Agency for Toxic Substances and Disease Registry****ENVIRONMENTAL PROTECTION AGENCY**

[ATSDR-40]

The Revised Priority List of Hazardous Substances That Will Be the Subject of Toxicological Profiles*Correction*

In notice document 91-25057 beginning on page 52166 in the issue of Thursday, October 17, 1991, make the following correction:

On page 52167, in the third column, in the first line, "concentrationsurface" should read "concentrations but are relatively less toxic. Concentration data in HAZDAT for air, water (surface)".

BILLING CODE 1505-01-D

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Food and Drug Administration****21 CFR Part 520****Animal Drugs, Feeds, and Related Products; Change of Sponsor***Correction*

In rule document 91-24169, beginning on page 50652, in the issue of Tuesday, October 8, 1991, make the following corrections:

§ 520.45a [Corrected]

1. On page 50653, in the first column, in § 520.45a, in the first line, "Albendazone" should read "Albendazole".

§ 520.2260b [Corrected]

2. On the same page, in the second column, in the first line, "Section 520.2260c" should read "Section 520.2260b".

§ 520.2260c [Corrected]

3. On the same page, in the same column, in the first line, "Section 520.2260b" should read "Section 520.2260c".

BILLING CODE 1505-01-D

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Health Care Financing Administration****42 CFR Part 483**

[BPD-662-F]

RIN 0938-AE50

Medicare and Medicaid Programs; Nurse Aide Training and Competency Evaluation Programs*Correction*

In rule document 91-22275 beginning on page 48880 in the issue of Thursday, September 26, 1991, make the following corrections:

§ 483.150 [Corrected]

1. On page 48919, in the first column, in § 483.150(a), in the first line, "aids" should read "aide".

§ 483.156 [Corrected]

2. On page 48921, in the third column, the section heading was printed incorrectly. It should read as set forth above.

BILLING CODE 1505-01-D

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Public Health Service****42 CFR Part 110**

RIN 0905-AC83

Vaccine Information Materials*Correction*

In rule document 91-24824 beginning on page 51798 in the issue of Tuesday, October 15, 1991, make the following corrections:

§ 110.103 [Corrected]

1. On page 51808, in the second column, in § 110.103, in the sixth line, "August 15" should read "April 15".

Appendix A to Subpart A [Corrected]

2. On the same page, in the 3d column, in the 22d line from the bottom of the page, "disease" should read "diseases".

3. On the same page, in the same column, in the 19th line from the bottom of the page, "risk" should read "risks".

4. On page 51809, in the first column, in the last line, insert a period after "protected".

5. On the same page, in the second column, in the eighth line from the top of the page, "DPT" should read "DTP".

6. On page 51811, in the second column, the headings in the blank form were printed incorrectly. The first heading should read "Problems". The second heading should read "Day and Time Problem Started".

7. On page 51813, in the third column, in the fifth line from the top of the page, "1 to 2" should read "1 to 3".

8. On the same page, in the same column, in the seventh line from the bottom of page, "getting" should read "get".

9. On page 51816, in the first column, in the first full paragraph, in the second line, "treatment" should read "treatments".

Editorial Note: For a related document, see the Rules and Regulations section in this issue of the Federal Register.

BILLING CODE 1505-01-D

INTERSTATE COMMERCE COMMISSION**Intent To Engage in Compensated Intercompany Hauling Operations***Correction*

In notice document 91-27010 beginning on page 57354 in the issue of Friday, November 8, 1991, make the following correction:

On page 57354, in the third column, entry 49 was omitted and should be inserted after entry 48 to read as follows:

49 Hunt-Wesson, Inc. (a Delaware corporation)

BILLING CODE 1505-01-D

INTERSTATE COMMERCE COMMISSION

[Nos. AB-322(Sub-No. 1X and AB-323 (Sub-No. 1X)]

NRUC Corp. Petition for Exemption-Discontinuance of Service and Operations in St. Lawrence County, NY and Ogdensburg Bridge and Port Authority-Petition for Exemption-Abandonment and Discontinuance of Service Between Ogdensburg and Waddington, in St. Lawrence County, NY

Correction

In notice document 91-1769 appearing on page 2948 in the issue of Friday, January 25, 1991, in the third column, in the file line at the end of the document, "FR Doc. 91-1768" should read "FR Doc 91-1769".

BILLING CODE 1505-01-D

Estimote Report

**Monday
November 25, 1991**

Part II

Department of Health and Human Services

Health Care Financing Administration

**42 CFR Parts 405, 413, and 415
Medicare Program; Fee Schedule for
Physicians' Services, Fee Schedule
Update for Calendar Year 1992 and
Physician Performance Standard Rates of
Increase for Federal FY 1992; Final Rules
and Notice**

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 405, 413, and 415

[BPD-712-F]

RIN 0938-AE91

Medicare Program; Fee Schedule for Physicians' Services

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: This final rule sets forth a fee schedule for payment for physicians' services beginning January 1, 1992. Establishment of this fee schedule is required by section 6102(a) of the Omnibus Budget Reconciliation Act of 1989, as amended by the Omnibus Budget Reconciliation Act of 1990. This final rule explains which services will be included in the fee schedule and sets forth the formula for computing payment amounts. Application of transition rules during 1992 through 1995 is also described, as well as other adjustments to fee schedule payment amounts.

DATES: These regulations apply to services furnished beginning January 1, 1992. These regulations are effective January 1, 1992.

ADDRESSES: To order copies of the *Federal Register* containing this document, send your request to: U.S. Government Printing Office, Order and Information Desk, Washington, DC 20402-9329.

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Copies of this final rule on high density 3.5 inch personal computer diskettes can also be obtained from the Government Printing Office by requesting stock number 069-001-00038-6. The file formats on the diskettes are

Word Perfect 5.0, Lotus 123 (version 2.01), and comma delimited ASCII files. The diskettes will be accompanied by the printed *Federal Register* document.

FOR FURTHER INFORMATION CONTACT: Terrence L. Kay, (410) 966-4494.

SUPPLEMENTARY INFORMATION:

Overview

In this final rule, we explain in detail the statutory authority for the physician fee schedule and the regulations under that authority. Addenda to this rule provide technical documentation to the fee schedule tables, tables containing relative values for physician services and geographic practice cost index values, and information to assist readers in obtaining documents referenced in this final rule.

This final rule adds a new 42 CFR part 415 to apply to physicians' services furnished beginning on January 1, 1992. Existing rules pertaining to reasonable charge payment at 42 CFR part 405, subpart E are being amended to reflect the more limited application of reasonable charge principles once the physician fee schedule becomes effective.

The information in this final rule updates the information supplied June 5, 1991 in the proposed rule (56 FR 25792). Elsewhere in the preamble of this final rule, we have summarized and responded to the comments received in response to the proposed rule and the proposed notice concerning "National Standardization of 'Global Surgery' Policy" that was published in the *Federal Register* on January 8, 1991 (56 FR 699).

To assist readers in referencing sections contained in this final rule, we are providing the following table of contents:

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- In addition, because of the many agencies and terms to which we refer by acronym in this final rule, we are listing those acronyms and their corresponding terms in alphabetical order below:
- AAO—American Academy of Ophthalmology
 - ACR—American College of Radiology
 - AFROC—Association of Freestanding Radiation Oncology Centers
 - AHPB—Adjusted historical payment basis
 - AMA—American Medical Association
 - APA—Administrative Procedure Act
 - ASA—American Society of Anesthesiology
 - ASC—Ambulatory surgical center
 - AWP—Average wholesale price
 - BMAD—[Part] B Medicare Annual Data
 - CAP—College of American Pathologists
 - CAT—Computerized axial tomography
 - CBO—Congressional Budget Office
 - CF—Conversion factor
 - CFR—Code of Federal Regulations
 - CHER—Center for Health Economics Research
 - CMD—Carrier medical director
 - CNS—Clinical nurse specialist
 - CP—Clinical psychologist
 - CPR—Customary, prevailing, and reasonable
 - CPT—Current Procedural Terminology, 4th Edition (copyrighted by the American Medical Association)
 - CRNA—Certified registered nurse anesthetist
 - CRVS—California Relative Value Studies
 - CSW—Clinical social worker
 - CWF—Common working file
 - CY—Calendar year
 - DHHS—Department of Health and Human Services
 - DME—Durable medical equipment
 - DO—Doctor of Osteopathy
 - DRG—Diagnosis-related group
 - EKG—Electrocardiogram
 - EO—Executive Order
 - ERCP—Endoscopic retrograde cholangiopancreatography

ESWL—Extracorporeal Shock Wave Lithotripsy
 FDA—Food and Drug Administration
 FTE—Full-time equivalent
 FY—Fiscal year
 GAF—Geographic adjustment factor
 GPCI—Geographic practice cost index
 HHA—Home health agency
 HCFA—Health Care Financing Administration
 HCPCS—HCFA Common Procedure Coding System
 HHS—Department of Health and Human Services
 HPSA—Health Professional Shortage Area
 HUD—Department of Housing and Urban Development
 IIC—Inflation-indexed charge
 JAMA—Journal of the American Medical Association
 LOCM—Low osmolar contrast media
 LPN—Licensed practical nurse
 MAAC—Maximum Allowable Actual Charge
 MAC—Monitored Anesthesia Care
 MCM—Medicare Carriers Manual
 MCP—Monthly Capitation Payment
 MD—Doctor of Medicine
 MEI—Medicare Economic Index
 MP—Multiple patients
 MRI—Magnetic resonance imaging
 MSA—Metropolitan statistical area
 MVPS—Medicare volume performance standards
 NAMCS—National Ambulatory Medical Care Survey
 NCH—National Claims History
 NF—Nursing facility
 NM—Nurse-midwife
 NP—Nurse practitioner
 OBRA—Omnibus Budget Reconciliation Act
 OIG—Office of the Inspector General
 OMB—Office of Management and Budget
 OT—Occupational therapist
 PA—Physician assistant
 Ph.D.—Doctor of philosophy
 PHS—Public Health Service
 Pub. L.—Public Law
 PPRC—Physician Payment Review Commission
 PPS—Prospective payment system
 PRMS—Puerto Rico Medical Society
 PRO—[Utilization and Quality Control] Peer Review Organization
 PT—Physical therapist
 RFA—Regulatory Flexibility Act
 RN—Registered nurse
 RVS—Relative value scale
 RVU—Relative value unit
 S&I—Supervision and interpretation (relates to coding of radiological services)
 SCVIR—Society of Cardiovascular and Interventional Radiology
 SMI—Supplementary Medical Insurance
 SP—Single patient
 SPECT—Single photon emission computed tomography
 TEFRA—Tax Equity and Fiscal Responsibility Act of 1982
 UI—Urban Institute
 UIP—University of Iowa Physicians

I. Background

A. Legislative History

The Medicare program was established in 1965 by the addition of

title XVIII to the Social Security Act (the Act). The Social Security Amendments of 1965 created two insurance programs: Medicare Part A or Hospital Insurance and Medicare Part B or Supplementary Medical Insurance. These original statutory provisions established the principles of reasonable charge payment for physicians' services and certain other services under Part B. The key provisions governing the reasonable charge payment methodology are set forth in sections 1833 and 1842(b) of the Act and in 42 CFR part 405, subpart E. While statutory amendments have moved certain Part B services such as radiologists' services, durable medical equipment (DME), and clinical laboratory services from reasonable charge payment to a fee schedule, physicians' services have generally been paid based on reasonable charge principles throughout the first 25 years of the program's operation.

In general, the reasonable charge for a physician's service is the lowest of: (1) The physician's actual charge, (2) the physician's customary charge, or (3) the prevailing charge in the locality for similar services. The customary charge is the median charge of the physician for the service during the July through June data collection period preceding the current calendar year (CY). These charges are arrayed in ascending order and the median or midpoint of the charge data is selected as the customary charge. The prevailing charge limit for a particular service in a locality is an amount set high enough to cover the full customary charges of the physicians whose billings have accounted for at least 75 percent (that is, the 75th percentile) of the charges in the locality for that service. Since 1975, changes in prevailing charge limits from year to year have been constrained by statute to the amount of inflation in medical costs as measured by the Medicare Economic Index (MEI).

A major change in the Medicare physician payment rules was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (Public Law 101-239) on December 19, 1989. Section 6102 of Public Law 101-239 amended title XVIII of the Act by adding a new section 1848, "Payment for Physicians' Services". The new section contains three major elements: (1) Establishment of volume performance standard rates of increase for physician services' expenditures; (2) replacement of the reasonable charge payment mechanism with a fee schedule for physicians' services; and (3) replacement of the maximum allowable charge (MAAC), which constrains the total amounts that

nonparticipating physicians can charge Medicare beneficiaries for covered services, with a new limiting charge.

On November 5, 1990, Congress enacted Public Law 101-508, the Omnibus Budget Reconciliation Act of 1990, which contained several modifications and clarifications to the Public Law 101-239 provisions establishing the physician fee schedule. These modifications have been taken into account throughout this final rule. Public Law 101-508 also made a number of revisions to physician payment amounts for 1991, which will affect payment amounts under the fee schedule, given the budget neutrality requirement for 1992 and the transition rules. (Budget neutrality is explained more fully in the discussion of the conversion factor (CF).)

This final rule is being issued in accordance with section 1848(b)(1) of the Act, as added by section 6102 of Public Law 101-239, which requires that: "Before January 1 of each year beginning with 1992, the Secretary shall establish, by regulation, fee schedules that establish payment amounts for all physicians' services furnished in all fee schedule areas * * * for the year." Section 1848 requires that the fee schedule include national uniform relative values for all physicians' services. The relative value of each service must be the sum of relative value units (RVUs) representing physician work, practice expenses net of malpractice expenses, and the cost of professional liability insurance (malpractice insurance). Nationally uniform relative values must be adjusted for each locality by a geographic adjustment factor (GAF). (Only one-fourth of the physician work relative value is subject to adjustment.) The CF (converting total RVUs into dollar payment amounts) must be budget neutral, so that had the fee schedule been applied during 1991 it would have resulted in the same level of aggregate payments as would be made under the reasonable charge system. The new fee schedule must be phased in over 4 years, beginning in 1992, with the new rules fully effective in 1996. During 1992 through 1995, transition provisions generally blend the old payment amounts with the new. In addition, this final rule sets forth a limit on amounts that nonparticipating physicians can charge beneficiaries under section 1848(g) of the Act. This new limit is called the limiting charge. The limit went into effect, as required by law, on January 1, 1991. Section 5302 of the Medicare Carriers Manual (MCM) explains the limiting charge.

B. Development of the Fee Schedule

Development of the concepts and methodology underlying the physician fee schedule has been under way for a number of years. Based on Congressional mandates contained in Public Law 99-272 (Consolidated Omnibus Budget Reconciliation Act of 1985), Public Law 99-509 (OBRA of 1986), and Public Law 100-203 (OBRA of 1987), we began our effort to develop a physician fee schedule based on a relative value scale (RVS). We were assisted in this task by a number of experts inside and outside of government, including the research team at the Harvard University School of Public Health led by William Hsiao, Ph.D. The Harvard research team produced "A National Study of Resource-Based Relative Value Scales for Physician Services" (September 1988) and "A National Study of Resource-Based Relative Value Scales for Physician Services Phase II" (November 1990) under a cooperative agreement with us. Harvard's Phase III final report has been received in installments throughout 1991 and is expected to be completed in December of 1991.

Other invaluable contributions were made by the Physician Payment Review Commission (PPRC), whose analyses and recommendations were extremely helpful to us at every stage of fee schedule development. The Urban Institute (UI) and the Center for Health Economics Research (CHER) were instrumental in the creation and refinement of the geographic practice cost indices (GPCIs), which were used to create the GAFs. The CHER also provided data and analyses to support the development of the global surgery and anesthesia service payment policies.

Under the statutory mandates listed above, we submitted three reports to Congress in October of 1989 ("Volume and Intensity of Physician Services", "Relative Value Scales for Physician Services", and "Implementation of a National Fee Schedule") that summarized the results of extensive research and analysis relating to the possible implementing of a Medicare physician fee schedule. These reports reviewed both the theoretical and practical implications of the transition to a fee schedule and simulated the effects of the change under various assumptions.

When Public Law 101-239 was enacted 2 months after the submission of these reports, the new law prescribed many of the procedures and methods to be used in implementing the fee

schedule on January 1, 1992, but a number of key payment policy and technical issues were left to the Secretary for resolution. Thus, section 6102(f)(11) of Public Law 101-239 required the Secretary to submit to the Congress and make available to the public a "model fee schedule" by September 1, 1990, in order to provide an early opportunity for public review of the fee schedule methodology. The model fee schedule was to include "as many services as the Secretary concludes can be assigned valid relative values".

The model fee schedule was published on September 4, 1990 as part of a notice with comment period (55 FR 36178). Its narrative portions described the statutory requirements, listed and explained the technical and policy issues left to the Secretary's discretion, and described steps that had been taken and that were planned in order to resolve the outstanding issues. Preferred options were identified in some cases; in other cases, options were discussed without identification of a preferred approach. The addenda to the model fee schedule notice provided preliminary estimates of the relative values associated with the approximately 1,400 services studied as part of the Harvard Phase I study as well as preliminary values for GPCIs for all existing Medicare localities. Using these tables, readers could compute preliminary estimates of payment amounts for particular services in particular localities under the fee schedule. We provided a 60-day public comment period; comments received were considered carefully and were helpful to us in developing the proposed rule that was published in the *Federal Register* on June 5, 1991 (56 FR 25792).

Based primarily on Phase II and some of Phase III of the Harvard study, the proposed rule contained relative values for more than 4,000 services representing about 85 percent of Medicare payments. In Phase II, 15 additional medical and surgical specialties were studied that were not studied in Phase I. In addition, seven Phase I specialties were restudied, with four of these restudies funded by the specialty societies. Not only did Phase II almost triple the number of services for which RVUs had been produced, but it refined the RVUs for many of the original 1,400 services. The preamble to the proposed rule also explained in much more detail the issues involved in aging the data to predict 1991 physician payments, computation of practice expense and malpractice RVUs, calculation of the budget-neutral CF,

computation of an adjusted historical payment basis (AHPB) for purposes of the transition, development of RVUs for technical component services, and many other aspects of the fee schedule. Although a policy was proposed for every issue, in many instances, multiple approaches were described and comments were invited. Those comments were useful to us in developing the final rule.

This final rule is based primarily on Phases II and III of the Harvard study, which produced RVUs for all but about 400 of the remaining Medicare-covered services that required work RVUs. In Phase III, (1) most of the extrapolated Phases I and II values were replaced by values that were generated by a small group survey process, and (2) many pre- and post-work estimates for Phases I and II work values were revised. A few early Phase III results were available for inclusion in the proposed rule; additional Phase III results were provided to us in installments throughout 1991. Those received by late Summer 1991 are reflected in this final rule. We developed RVUs for roughly 400 services that had not been surveyed by Harvard (generally low volume services or nonphysician services or services that were extrapolated by Harvard). Physician work RVUs were reviewed and developed by carrier medical directors (CMDs), initially through a survey conducted by mail and subsequently through group meetings to refine the product of the survey process. Through a consensus or Delphi-type process, CMDs rated physician work for the remaining services. In addition, a number of physician work relative values were refined based on information provided as part of the comment process on the proposed rule. Discussion of these refinements is included later in this preamble as part of the analysis of comments.

C. Summary of the Provisions in the Proposed Rule

The June 5, 1991 proposed rule set forth proposed RVUs for physician services under the fee schedule, proposed GPCI values, and proposed policies on a wide range of fee schedule and limiting charge issues left to Secretarial discretion by Public Law 101-239 and Public Law 101-508. Highlights of that proposed rule (including provisions explicitly specified in the statute) are summarized below.

- The fee schedule would apply to physician services; services of limited licensed practitioners, diagnostic tests other than clinical diagnostic laboratory tests; diagnostic and therapeutic

radiology services; and physical and occupational therapy.

- Payments to various nonphysician practitioners, although not payable under the fee schedule, would be based on fee schedule payments.

- The proposed rule provided preliminary physician work, practice expense, and malpractice RVU values for services that had been studied by the Harvard research team and explained in general terms our proposed process for "gap-filling" values not expected to be provided by Harvard.

- The existing radiologist fee schedule would be integrated into the overall physician fee schedule as required by statute. While the relationships among RVUs for services in the existing fee schedule must be preserved, the entire fee schedule must be rescaled to link radiology services to equivalent nonradiology services in the physician fee schedule.

- The proposed rule included policies for a number of special situations related to radiology services, including portable x-ray services, interventional services, payments that recognize the type of equipment used, and low osmolar contrast media (LOCM).

- Since there has been great variation in the use of present visit codes, new visit codes developed by the CPT Editorial Panel would be adopted.

- Payment for surgical services would include a standard package of pre-operative, intra-operative, and post-operative services.

- A site of service differential would be established. For services commonly performed in physicians' offices, the practice expense RVUs would be adjusted if the service is furnished in a hospital outpatient department.

- Although Public Law 101-508 precludes separate payment for EKG interpretations by physicians, the visit RVUs would be increased to include an allowance for the EKG interpretation.

- Anesthesia services would be integrated into the overall physician fee schedule, as required by statute. In conjunction with this integration, actual time units would be eliminated as an element in payment for anesthesia services furnished by physicians or certified registered nurse anesthetists (CRNAs). Estimates of the average time each anesthesia procedure takes to perform would be factored into the RVUs.

- Services of nonphysicians that are covered incident to a physician's service would be paid under the fee schedule as if the physician had furnished the service.

- Payment would be made for nonself-administrable drugs outside the

physician fee schedule. Carriers would base payment on 85 percent of the national average wholesale price.

- Except for drugs and specified expensive supplies, office medical supplies would be considered practice expense to the physician and included in the practice expense RVUs.

- The budget-neutral CF would reflect adjustments to take into account: (1) the net cost associated with the asymmetrical transition rules in the statute; and (2) anticipated volume and intensity responses to changes in fees. The CF would be calculated by using 1989 claims data "aged" to 1991 (updated to reflect legislative changes and other changes).

- The GAFs for fee schedule payments would be based on work done by the UI and the CHER.

- A standard list of payment modifiers would be established that would affect payment (for example, multiple surgery).

A more detailed description of the statutory requirements, proposed provisions, rationale for the proposed policy, and the other alternatives we considered is contained in the proposed rule (56 FR 25795). Also, proposed rule policies are discussed in the narrative paragraphs that precede comments and responses in section III of this preamble (Summary of Analysis of Comments and Responses).

D. Number and Types of Public Comments

In response to the publication of the proposed rule on June 5, 1991 in the **Federal Register**, we received approximately 95,000 timely items of correspondence. Comments were received from a wide variety of correspondents, including professional associations and societies, health care workers, law firms, advocacy groups, third-party health insurers, clinical research groups, pharmaceutical companies, medical schools, teaching hospitals, private individuals, and members of Congress. We have summarized these comments and our responses in section III of this preamble.

In addition, we have summarized and responded to the comments received in response to the proposed notice concerning "National Standardization of 'Global Surgery' Policy" that was published in the **Federal Register** on January 8, 1991 (56 FR 699). The comments, for the most part, were resubmitted or duplicated the comments received in response to the June 5, 1991 proposed rule. We have included the comments and our responses in this final rule in lieu of publishing a separate final notice.

II. Summary of the Provisions in This Final Rule

In this section we provide brief summaries of the provisions of the final rule. Information about the statutory requirements for establishing the physician fee schedule and the differences between the policies proposed on June 5, 1991 and the policies in the final rule is provided in section III of this preamble (Analysis of Comments and Responses).

A. Services to be Included in the Fee Schedule

1. Physicians—General

Section 1848(a)(1) of the Act (as added by section 6102 of Public Law 101-239) requires that payment be made under the physician fee schedule for all physicians' services, as defined in section 1848(j)(3) of the Act, including: Professional services of physicians; services and supplies incident to physicians' services (except drugs, which we will exclude); outpatient physical and occupational therapy; diagnostic X-ray and other diagnostic tests; and X-ray, radium, and radioactive isotope therapy (§ 415.2, definition of "Physicians' Services").

2. Limited Licensed Practitioners

The physician fee schedule will apply to optometrists, dentists, oral and maxillofacial surgeons, podiatrists, and chiropractors when they furnish specific services for which the law considers them to be physicians.

3. Nonphysician Practitioners

a. *Physical/occupational therapists (PT/OTs).* Physical and occupational therapy services furnished in an independent practice will be paid under the physician fee schedule. Physical, occupational, and speech therapy services that are covered when furnished by a provider of services (for example, a hospital and nursing facility (NF)) will not be affected by implementation of the physician fee schedule. That is, payment for physical therapy services furnished in provider settings will continue to be part of payment to that provider and not separately paid to the practitioner furnishing the physical therapy services.

b. *Physician assistants (PAs).* Under the statute, allowed charges for assistant-at-surgery services furnished by PAs will be limited to 65 percent of the physician fee schedule amount § 415.50. The allowance for services furnished in a hospital, other than assistant-at-surgery services, will be limited to 75 percent of the physician fee

schedule amount. The allowance for all other PA services will be limited to 85 percent of the physician fee schedule.

c. *Nurse practitioners (NPs) and clinical nurse specialists (CNSs)*. The law limits allowed charges for services of NPs furnished in NFs covered under section 1861(s)(2)(k)(ii) of the Act to 85 percent of the physician fee schedule amount. For services of NPs and CNSs covered under section 1861(s)(2)(k)(iii) furnished in rural areas as defined for the hospital prospective payment system (PPS), the allowed amount will be limited to the lower of the actual charge or 75 percent of the physician fee schedule amount for services furnished in a hospital; and 85 percent of the physician fee schedule amount in all other settings (§ 415.54).

d. *Certified registered nurse anesthetists (CRNAs)*. We will use the same RVS for determining payment for both physician anesthesia services and CRNA services (§ 415.58). For a specific anesthesia code, the RVUs for the CRNA service will be the same as the RVUs for an anesthesia service personally performed by the anesthesiologist. The CF for a non-medically directed CRNA will be limited to the anesthesia CF applicable in that locality. We will not apply a limit on the CF for services of medically directed CRNAs.

e. *Nurse-midwives (NMs)*. Payment for NMs will be limited to 65 percent of the physician fee schedule amount (§ 415.52).

f. *Clinical psychologists (CPs)*. Diagnostic tests furnished by CPs will be paid under the physician fee schedule like all other fee schedule services. (Therapeutic and other diagnostic services of CPs will be paid under a separate rule, which is still being developed.)

g. *Clinical social workers (CSWs)*. Covered diagnostic tests furnished by CSWs will be paid under the physician fee schedule like all other fee schedule services (§ 415.60) (Psychological testing services, however, are covered only if furnished by physicians or qualified psychologists). Therapeutic and other diagnostic services of CSWs will be limited to 75 percent of the fee schedule for CPs.

4. Provider-Based and Teaching Physicians

Direct patient care services of provider-based physicians, including those in teaching hospitals, with the exception of those under the cost election provision, will be paid under the physician fee schedule on the same basis as other physician services. The attending physician criteria (§ 405.521)

for teaching physicians will remain in effect under the physician fee schedule.

5. Payment for Supplies, Services, and Drugs Furnished Incident to a Physician's Service

a. *Supplies*. Office medical supplies, except for drugs and certain supplies associated with performing the procedures listed in Addendum G of this final rule, will be considered to be practice expenses to the physician and payment will be included in the practice expense portion of the payment for a medical or surgical service to which they are incidental (§ 415.34(a)).

For procedures in Addendum G, we have established a practice expense RVU of 1.0 for supplies that are used incident to a physician's service but generally are not the type of routine supplies that are included in the practice expense RVU for specific physicians' services. We will pay, however, a separate allowance based on an RVU of 1.0 only if these supplies are billed (using procedure code A4550) in conjunction with procedures listed in Addendum G, and these procedures are performed in physicians' offices. The GPCI will not be applied to determine payment for supplies.

b. *Services*. Services of a nonphysician that are covered incident to a physician's service will be paid under the fee schedule as if the physician had furnished the services (§ 415.34(b)).

c. *Drugs*. We will use a standard method to pay for drugs (§ 405.517). We will base payment for a drug on the lower of the estimated acquisition cost or the national average wholesale price of the drug. If a drug has multiple sources, the median of the average national wholesale generic prices will be used. Estimated acquisition costs will be determined based on surveys of actual invoice prices paid by the providers furnishing the drug. In calculating estimated acquisition costs, indirect costs such as inventory, waste, and spoilage may be considered.

We are clarifying in § 405.517 that the payment policy for drugs applies to all drugs furnished to Medicare beneficiaries that are not paid on a cost or prospective payment basis. This includes drugs furnished by independent ESRD facilities. Accordingly, we are adding a new paragraph (c)(7) to § 413.170 that describes the payment rules for drugs furnished by ESRD facilities.

B. Formula for Computing Payment Amounts

Section 1848(a) of the Act specifies that payment for Medicare physicians'

services must be based on the lesser of the actual charge or the payment amount computed under the fee schedule. Although the law refers to the fee schedule values as "payment amounts", in fact under the statutory formula the amount paid directly to a physician or beneficiary by Medicare will be 80 percent of the actual charge or 80 percent of the fee schedule payment amount, whichever is less. The beneficiary is required to pay the remaining 20 percent. (Throughout this final rule, we have used the terms "fee schedule payment amount," "payment amount," "payment," and "allowed charge" as used in the statute to include the amounts for which both the beneficiary and Medicare are responsible.)

Under the formula set forth in section 1848(b)(1) of the Act, payment amounts for particular services under the physician fee schedule will be computed as the product of three factors: (1) A relative value for the service, (2) the GAF for the fee schedule area, and (3) a nationally uniform dollar CF. (Although we generally describe a single nationally uniform CF, different CFs for surgical services and other services may be established as part of the Medicare volume performance standards (MVPS) and annual update process. A discussion of the update process appears in the section on "the CF.") This general formula can be expressed as:

$$\text{Payments} = \text{RVU}_s \times \text{GAF}_{sa} \times \text{CF}$$

where

RVU_t = Total relative value units for the service

GAF_t = Total geographic adjustment factor for the fee schedule area

CF = Uniform national CF

_s = Service

_a = Fee schedule area

Section 1848(e)(2) of the Act requires the total GAF for a fee schedule area to be the sum of three components, relating to the three components of the total RVU for a service. The three components are:

(1) Physician work;

(2) Practice expenses or overhead, such as rent, staff salaries, equipment, and supplies, exclusive of professional malpractice liability insurance costs; and

(3) Professional liability insurance or malpractice costs.

Section 1848(c)(1) of the Act defines the components of the RVU for a physician service. The physician work RVU must reflect the physician resources required to furnish the service, including time and intensity of effort. Under the formula specified at section

1848(c)(2)(C), the practice expense and malpractice RVUs are based on historical data for practice expense as a fraction of total physician revenue, weighted by specialty, applied to estimated 1991 average allowed charges under the customary, prevailing, and reasonable charge methodology.

Separate GPCIs have been developed for the three components of the fee schedule. Under section 1848(e) of the Act, the GAF is equal to a weighted average of these three GPCIs. Thus, when the GAF is expressed as the sum of its three components, the formula becomes:

$$\text{Payments} = \text{RVU}_w \times [(GPCIw_a \times w_s\%) + (GPCIpe_a \times pe_s\%) + (GPCIma_a \times m_s\%)] \times CF$$

where

$GPCIw_a$ = GPCI value reflecting one-fourth of geographic variation in physician work applicable in the fee schedule area

$GPCIpe_a$ = GPCI value for practice expense applicable in the fee schedule area

$GPCIma_a$ = GPCI value for malpractice expense applicable in the fee schedule area

$w_s\%$ = Work percentage for service,

$pe_s\%$ = Practice expense percentage for service,

$m_s\%$ = Malpractice percentage for service,

The work, practice expense, and malpractice percentages are the fraction of the total RVUs for a service represented by the work, practice expense, and malpractice RVUs, respectively; they sum to 100 percent.

In effect, this statutory formula accomplishes separate adjustment of each of the three components of the total RVUs for each service by the value for the fee schedule area of a GPCI specific to that component. (The statute specifies, however, that only one-fourth of the geographic variation in physician work resource costs is to be taken into account in the formula.) The three GPCI-adjusted RVU values are summed to produce a total RVU value, which is converted into a dollar payment amount specific to that service and that fee schedule area by application of a uniform, national CF. Thus, for ease of computation and understanding, we have transformed the original formula stated above into an algebraic equivalent as follows:

$$\text{Payments} = [(RVUw_s \times GPCIw_a + (RVUpe_s \times GPCIpe_a) + (RVUma_s \times GPCIma_a))] \times CF$$

where

$RVUw_s$ = Physician work relative value units for the service

$RVUpe_s$ = Practice expense relative value units for the service

$RVUma_s$ = Malpractice relative value units for the service

Sources of each of these elements of the payment formula are explained in more detail in the sections below. Included within the discussion of the CF computation below is an explanation of payment rules during the transition years 1992 through 1995.

C. Sources of Relative Value Units (RVUs)

1. Physician Work RVUs

The physician work RVUs are based primarily on the work of the Harvard research team. We used a group of CMDs to review the comments received on the work RVUs in the proposed rule (most of these RVUs came from Harvard), to fill gaps in the Harvard RVS, and to resolve anomalies that we identified in our review of the Harvard RVUs. The list of RVUs for physician work is contained in addendum B. Changes we made to the proposed work RVUs are discussed in section III, Summary of Analysis of Comments and Responses.

The work RVUs shown in addendum B are considered to be "initial" RVUs. We will accept comments on the initial RVUs only if they are received at the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: BPD-712-F, P.O. Box 26688, Baltimore, MD 21207.

Comments must be received no later than March 24, 1992, to ensure consideration in establishing the fee schedule for 1993. In accordance with the Administrative Procedure Act (APA), we normally allow 60 days for the receipt of public comments on rulemaking documents. Nevertheless, since these RVUs are a significant part of the major reform for payment to physicians who furnish Medicare services and because we anticipate that any revision in RVUs would be effective January 1, 1993, we have decided to allow 60 additional days, or 120 days for receipt of comments.

2. Unlisted Procedures, Local Codes, and Carrier Priced Services

Carriers will individually value services billed under unlisted (that is, generally CPT codes ending in "99") procedure codes and other services for which we have not established work values (for example, some low volume services such as surgery to correct congenital anomalies) after review of pertinent medical information that describes the services furnished.

New procedures for which there is no national code will be assigned a local code and will be paid under the fee schedule using relative values

determined by the carriers until a national code is established.

We will minimize the use of local codes by requiring that carriers acquire prior approval from us for the use of local codes; annually reviewing all local codes to identify those that should be moved to the national coding system; and establishing national HCPCS codes for new services deemed not appropriate for inclusion in the Current Procedural Terminology (CPT), 4th Edition (copyrighted by the American Medical Association (AMA)).

There are about 670 national HCPCS codes that will be priced by carriers for 1992. They fall into the following categories:

- About 310 codes are dental codes that are seldom covered and for which we have no reliable charge data or work RVUs. The more frequently covered oral surgical services are crosswalked to the CPT code for the service and will be priced identically to the CPT code for the service.

- About 95 codes are codes for services "not otherwise classified" or "unlisted" services (for example, 95199, unlisted allergy/clinical immunologic service or procedure). These are miscellaneous categories of undefined services for which work effort varies widely and which require individual consideration by the carriers.

- About 10 codes are codes for services at the extremely high level of the RVS that we had difficulty rating. These procedures, such as liver transplants, have relatively low Medicare frequency, are extremely difficult, and are performed on patients with very complex and serious medical conditions. We believe these cases should be carefully reviewed by a CMD and priced individually. We expect, however, to establish RVUs for these services in the 1993 fee schedule.

- About 210 codes are codes for a mixture of services for which we could not develop a work value because the definition of the code does not specify a service sufficiently to enable us to value it, or because they are services uncommonly performed for the Medicare population. Most of these codes are of low Medicare frequency.

3. RVUs for Limited Licensed Practitioner Services

Harvard studies have provided many physician work RVUs for services that are furnished by limited licensed practitioners as well as by doctors of medicine (MDs) and doctors of osteopathy (DOs) (that is, limited licensed practitioners oftentimes use the same codes as MDs and DOs). Section

1848(c)(6) of the Act prohibits the Secretary from imposing different RVUs or a different CF for a physician's service based solely on the specialty of the physician. Thus, insofar as the services furnished by limited licensed practitioners are the same as those furnished by MDs and DOs, we are required by law to provide the same payment amounts for those services.

4. Radiology Services

a. *Integration of existing radiologist fee schedule into the physician fee schedule.* In establishing the physician fee schedule, the language of Public Law 101-239 acknowledges that special rules are already in effect with respect to payment for radiology services. The radiologist fee schedule presently applies to radiology services furnished by or under the supervision of a physician certified or eligible to be certified by the American Board of Radiologists or by a physician for whom radiology services account for at least 50 percent of the total amount of charges made under Medicare Part B. The radiologist fee schedule values are based on an RVS developed by the American College of Radiology (ACR) that we adopted.

b. *Rescaling values for the physician fee schedule.* As required by law, we integrated the current radiologist fee schedule into the overall physician fee schedule. We preserved the current relationships among radiology services while making appropriate modifications to develop consistent relationships between radiology services and all other physician services. We integrated the work, practice expense, and malpractice RVUs separately. The practice expense and malpractice RVUs are based on the 1991 national average payment allowances and were developed in a manner consistent with practice expense and malpractice RVUs for nonradiology services.

To develop the work RVU, we multiplied the unweighted mean ratio of the Harvard to radiologist fee schedule work values by each radiologist fee schedule work RVU to place all work RVUs on the Harvard scale. The calculation of the unweighted mean ratio was based on 65 procedures studied by Harvard.

c. *Portable X-ray.* Services of portable x-ray suppliers consist of 3 components: Professional, technical, and transportation (that is, transporting equipment to a beneficiary).

In the interim final rule implementing the radiologist fee schedule (54 FR 8999), we instructed carriers to establish CFs for the services of portable x-ray suppliers separate from the CFs

applicable to the services of all other entities. Section 1848(c)(6) of the Act precludes the recognition of specialty differentials under the fee schedule. Therefore, all three components of the services of portable x-ray suppliers will be paid under the physician fee schedule using the same CF as applies to all other services payable under that fee schedule. However, in recognition of the additional costs incurred by portable x-ray suppliers associated with setting up equipment and positioning patients in nursing homes and patient homes, we have established a Level II HCPCS code and national RVUs reflecting an equipment set-up fee per procedure. The RVUs were established based on the national average difference in payment levels for a sample of high volume procedures furnished by portable x-ray suppliers and allowances for procedures furnished by other x-ray suppliers.

We have also instructed carriers to continue to price transportation costs locally.

d. *Interventional radiological services.* Consistent with the changes in the 1992 edition of the CPT, we are discontinuing use of complete procedure codes for these services. Payment of the full fee schedule allowance will be made for the radiological portion (that is, the supervision and interpretation (S&I) code) of an interpretative radiologic service (that is, surgical code). In addition, for any other procedure code associated with the procedure, we will pay 50 percent of the amount that would be otherwise payable for the first additional procedure, and 25 percent for up to 3 additional procedures. (Additional procedures beyond the 3 paid at 25 percent would be payable by report.) We will not reduce payments for any procedure code for which the RVUs already reflect a multiple procedure reduction.

e. *Technical component of radiation oncology services.* The RVUs for the technical component of radiology services are generally based on the estimated average allowance for each technical component service based on the radiologist fee schedule. However, on the basis of our analysis of the costs of freestanding radiation oncology centers, we have concluded that an increase in the RVUs is needed to more adequately cover their costs. We are increasing the RVUs for the technical component codes by 14.2 percent.

In addition, we will discontinue the recognition of local codes for radiation treatment services. We are deferring action on establishing a payment differential based on the equipment used in furnishing therapy. Finally, we

are making codes 77336 and 77370 technical component-only codes and assigning the RVUs formerly assigned to the professional component totally to this service.

f. *Low osmolar contrast media (LOCM).* Divergent payments exist among carriers for LOCM, also known as non-ionic contrast material, for radiological studies. We will pay separately for LOCM if it is used for patients with specified characteristics under the standard methodology for payment of drugs generally. That is, we will base payment on the lower of the estimated actual acquisition cost or the published wholesale price of the drug. The estimated acquisition costs will be determined based on carrier surveys of actual invoice prices paid by physicians.

5. Anesthesia Services

a. *Integration of anesthesia services into the physician fee schedule.* In accordance with section 1848(b)(2)(B) of the Act, we have used, to the extent practicable, the anesthesia uniform relative value guide, with appropriate adjustment of the CF, to assure that the fee schedule amounts for anesthesia services are consistent with the fee schedule amounts for other services determined by the Secretary to be of comparable value. In addition, we have adjusted the anesthesia CFs by GAFs in the same manner as the adjustment is made for other physicians' services.

b. *Continuation of recognition of time.* We have decided to retain temporarily the use of actual time for this final rule. Our principal reason is that we believe further work needs to be done on the coding system to assure that there is homogeneity in the procedures classified within a single anesthesia code. We will continue to analyze the issue with the goal of eliminating actual time soon.

Since we will retain temporarily the use of actual time, we will use a CF for anesthesia services that is separate from the CF for the overall fee schedule. We will continue to use the anesthesia uniform relative value guide consisting of base units per procedure and 15- and 30-minute time units for personally performed and medically directed services, respectively. Also, we will continue to follow the provisions in current law requiring that payment for concurrent medical direction services be reduced as follows: 10 percent in the base units for 2 concurrent procedures, 25 percent in the base units for 3 concurrent procedures, and 40 percent in the base units for 4 concurrent procedures.

As required by law, we are adjusting the anesthesia CF to assure that the fee schedule amounts for anesthesia services are consistent with the fee schedule amounts for other services determined to be of comparable value. We determined the extent to which the work component of anesthesia services was overvalued and reduced the work component of the 1991 national average anesthesia CF by this percentage.

As a result of this calculation, we determined that the current national anesthesia CF should be reduced by 29 percent. Thus, the 1992 national CF for anesthesia services will be \$13.94.

Given the fact that we are retaining a separate anesthesia CF, the limitation in the law that the CRNA CF for non-medically directed CRNA services not exceed the CF for physician anesthesia services will be applied without requiring the adjustment described in the proposed rule.

While we have decided to continue temporarily the use of actual time for this final rule, we have serious reservations about paying anesthesia services on a different basis than all other physician services. We also continue to believe that the current definition of anesthesia time is not precise and leads to wide variation in the reporting of time. We will be intensively examining the issue of how to pay for anesthesia services in the future with the goal of eliminating actual time.

For the short term, we are revising our definition of "anesthesia time" consistent with the recommendation of the American Society of Anesthesiology (ASA). For this purpose, anesthesia time involves the continuous actual presence of the anesthesiologist (or of the medically-directed CRNA or resident) and starts when he or she begins to prepare the patient for anesthesia care in the operating room and ends when the anesthesiologist is no longer in continuous actual attendance, that is, when the patient may be safely placed under post-operative supervision.

Moreover, we are instructing our carriers to closely monitor the use of actual time reporting for high volume procedures. To assist them in this effort, we are sharing information we have developed on average time per procedure.

c. *Payment for specialized services furnished by anesthesiologists.* We will allow separate payment for specialized procedures such as Swan-Ganz catheters and central venous pressure lines furnished by anesthesiologists if these procedures are furnished in conjunction with an anesthesia procedure or as an unrelated procedure.

These procedures must be reasonable and necessary and not included as services paid under the global surgical fee. Our manual instructions will identify the circumstances under which separate payment can be made for these services.

d. *Monitored anesthesia care.* We have provided for a uniform modifier to be used with the anesthesia code to identify monitored anesthesia care on the claim form.

e. *Attending physician relationship.* We will recognize an attending physician relationship if a teaching anesthesiologist is involved in two concurrent procedures involving interns or residents (§ 415.44). That is, we will recognize an unreduced fee if a teaching anesthesiologist is involved in two concurrent procedures involving interns or residents. However, beginning in 1994, we will recognize the unreduced fee only if a teaching anesthesiologist is involved in a single procedure with an intern or resident.

6. Physician Pathology Services

Of the approximately 1,100 services listed in the pathology section of the CPT, only 59 services are identified as physician pathology services. The remainder of pathology services are generally considered clinical diagnostic laboratory services and are excluded from the physician fee schedule by section 1848(j)(3) of the Act. We have established relative values for the physician work associated with physician pathology services.

Public Law 101-508 also requires that we consider an appropriate adjustment to reflect the technical component of furnishing physician pathology services through a laboratory that is independent of a hospital and separate from a physician's office. We have established the technical component of physician pathology services as 15 percent of the professional component amount.

As indicated in Addendum B, some of the pathology codes have both a professional and technical component value. A lesser number of codes have a professional component only or technical component only.

We have also defined a new category of service, clinical laboratory interpretation services. We have identified 15 clinical laboratory codes for which a separate payment under the physician fee schedule can be made for a clinical laboratory interpretation service if the interpretation service is requested by the patient's attending physician, result in a written narrative report, and requires the exercise of medical judgment by the pathologist. A standing order for an interpretation by

the attending physician can meet the definition of a request for this purpose.

Currently, in § 405.556(a)(3), we cover as physician pathology services the services performed by a physician in the personal administration of test devices, isotopes, or other materials to an individual patient. Since there are no physician pathology services that fall under this category, we are deleting § 405.556(a)(3).

7. Charge-based Computation of Practice Expense and Malpractice RVUs

Consistent with section 1848(c)(2)(C) of the Act, we are computing practice expense and malpractice RVUs by applying historical practice cost percentages to a base allowed charge for each service. That is, for each service, we multiplied the 1991 average allowed charge by the historical practice expense percentage that was determined as a weighted average of the practice expense shares for the specialties performing the service as reflected in the Medicare charge data.

To determine the practice expense shares, we used 1989 data from the AMA's Socioeconomic Monitoring Survey for physician specialties. We used the practice expense shares for all physicians for specialties not included in the AMA data. For some of the limited licensed and nonphysician specialties, we used practice cost data obtained through surveys by the specialty societies themselves.

We found that there were about 245 codes for which we had established work RVUs, but for which there was no historical data on which to base practice expense and malpractice expense RVUs. Many of these services are new codes in 1992 for which we have no reliable way of crosswalking data, but for which we have established work RVUs.

We calculated practice expense and malpractice expense RVUs for these services by imputing them from the work RVU for the service. We generally used the specialty percentages when we knew the specialty most likely to furnish the service, and we used the "all physician" percentages when we were not sure of the specialty that would furnish the service or when we believed several specialties may furnish the service. Essentially, we derive the total RVUs from the work RVUs and then apply the specialty practice cost shares to determine the practice expense and malpractice RVUs. For example, if a procedure has a work RVU of 6, and the specialty practice cost percentages for the specialty furnishing the service is 60 percent work, 30 percent practice expenses, and 10 percent malpractice,

then the total RVUs are 10 ($6 \div .60$) and the practice expense RVU would be 3 (that is, $10 \times .30$), and the malpractice RVU would be 1 (that is, $10 \times .10$).

We also used this methodology to set practice expense and malpractice RVUs for services with volumes so low that we lacked confidence in the charge data (generally procedures with national frequencies under 50). We believe that this is a valid means of setting these RVUs absent historic charge data and we expect to continue to impute practice expense and malpractice expense RVUs for new services in the future using similar methods.

8. Combining Work, Practice Expense, and Malpractice RVUs Onto a Common Scale

The work RVU was initially scaled in units selected by the Harvard study, whereas the practice expense and malpractice RVUs were initially computed in dollar units. We have chosen to convert Harvard work RVUs to dollar units and then to rescale all RVUs relative to the new Level 3 established office visit (CPT code 99213) (for which total RVUs will equal 1.00). The work RVUs in Addendum B can be multiplied by 94.216 to approximate the value on Harvard's Phase II scale.

9. Periodic Review and Adjustments in RVUs

a. *Establishing RVUs for new services and changing RVUs for existing or revised services.* We will announce RVUs for new services and changes in RVUs already in effect by publishing a proposed notice in the **Federal Register** with an opportunity for public comment no less often than every 5 years (§ 415.24(a)). After reviewing the public comments, we will publish a final notice in the **Federal Register** to announce additions or revisions to RVUs.

We will provide an "interim value" process that will allow us to quickly implement national RVUs for new or revised codes (see § 415.24). No retroactive changes in RVU values or payments will be made; changes from interim to final values will be made prospectively.

We expect that physician organizations will propose codes and RVUs for new services and will also propose changes to RVUs for current codes. We expect to use a group process involving the CMDs to help us evaluate these requests and to fill gaps for new services for which we may not receive proposed RVUs from physician organizations.

The "interim value" process will likely result in additional values being added to the physician fee schedule each year

because the CPT revises and deletes some codes each year. The AMA has proposed that the CPT process be expanded to produce recommendations regarding RVUs for newly coded services, RVUs for services with revised codes, and changes to standing RVUs.

We will consider recommendations from the CPT process or from any other specialty societies or other groups regarding new or revised codes. We may also elicit advice from the CMDs before we use the recommended values as initial values. Moreover, any recommendations received from the CPT process will not constitute the exclusive means for us to receive advice and recommendations on new or revised values. Specialty societies or other groups can submit their recommendations directly to us and we will consider them as well. Finally, the interim values will be subject to comment before they become standing RVUs. Changes to standing RVUs will only be implemented through publication of proposed and final **Federal Register** notices.

b. *Implementation of the \$20 million limitation.* In accordance with section 1848(c)(2)(B)(ii)(II) of the Act, we will make adjustments to RVUs as a result of changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures without causing the amount of expenditures under Part B for the year to differ by more than \$20 million from the expenditures that would have been paid had the adjustments not been made. Therefore, the adjustments will be essentially budget neutral (within a \$20 million tolerance per year), based on the expected expenditures for the year.

D. Geographic Adjustment Factors (GAFs)

The statute specifies that the total RVUs for a service must be adjusted by the GAF. The GAF is equal to a weighted average of the individual adjustment factors or GPCIs for each of the three RVU components—work; practice expense (exclusive of malpractice), referred to throughout this rule simply as "practice expense"; and malpractice.

Section 1848(e) of the Act requires the Secretary to develop GAFs for all physician fee schedule areas. It requires an index to reflect the relative practice expenses compared to the national average; an index to reflect the relative malpractice expenses compared to the national average; and an index to reflect one-quarter of the relative cost of physicians' work compared to the national average. The law does not specify the methodology to be used in

developing these GPCIs, instead it leaves the methodology to the discretion of the Secretary.

Components of a GAF were already under development as a result of Public Law 99-509, which required the Secretary to develop an index by December 31, 1989 to measure "justifiable" geographic differences in physicians' costs of furnishing services. As a result of this provision, alternative GPCIs were developed by the joint efforts of the UI and CHER. See addendum D of this final rule for information regarding how to obtain copies of their reports.

A list of the GPCIs for all current Medicare localities in the form required by section 1848(e) of the Act appears at addendum C of this final rule. The GAF used in the physician fee schedule is based on the research performed by UI and CHER. The GPCIs in this final rule, which will go into effect January 1, 1992, differ slightly from those announced in the proposed rule in the following ways:

- We are replacing the locality GPCIs with Statewide GPCIs for Oklahoma, Nebraska, and Minnesota, since these States will become single Statewide localities in 1992.

- We are deleting the locality GPCIs for Iowa locality 8, Iowa City. These GPCIs are being combined with the GPCIs for Iowa locality 1, resulting in a slightly revised GPCI for locality 1 (see discussion on localities).

- We are making minor changes in a small number of GPCIs as a result of some corrections in the mapping between counties and Medicare localities. These changes are so minor that no national renormalization is required.

E. Conversion Factor (CF)

1. Computation of Budget-Neutral CF

Under the statute, the general formula for a payment amount under the fee schedule multiplies a relative value for a service by a GAF for a fee schedule area by a CF. Thus the CF can be viewed as a multiplier that transforms relative values into payment amounts. The CF is a single national value that will apply to all services paid under the fee schedule (except that different CFs for surgical and nonsurgical services may eventually result from differential updates under the MVPS). Section 1848(d)(1)(B) of the Act specifies the methodology for setting the CF for the first year of the fee schedule (1992). A base year CF must be computed that is budget-neutral relative to 1991 predicted expenditure levels. That is, this base CF must produce total payments under the fee schedule that

are the same as total payments that are expected in 1991 under the current payment rules (generally based on the customary, prevailing, and reasonable charge methodology). The CF for 1992 will be established by updating this base year CF by the annual update factor.

2. Accounting for Transition Payment Rules in CF Calculation

Under the transition rules, as set forth in section 1848(a)(2) of the Act, the fee schedule will be phased in from CYs 1992 through 1995. The phase-in will begin with computation of an AHPB or historical payment amount for each service in each fee schedule area. For non-radiology services, this is defined in section 1848(a)(2)(D)(i) of the Act as the weighted average prevailing charge in the area in CY 1991 with consideration of customary charges below the prevailing and other payment limitations, adjusted by the annual update applicable to CY 1992 payments. (Computation of this update amount is discussed at the end of this CF discussion.) Under the law, we have calculated a separate AHPB for each procedure in each fee schedule area. To maintain budget neutrality, the AHPB for all services will be reduced by 5.5 percent. This adjustment is necessary because of the asymmetric nature of the transition. There is no permanent reduction in the fee schedule due to this adjustment.

Under the statutory transition rules, if the historical payment amount for a service in a fee schedule area is from 85 to 115 percent of the fee schedule amount, maximum payment to all physicians in the fee schedule area will be at the fee schedule amount in CY 1992. However, if the historical payment amount is below 85 percent of the fee schedule amount, the payment amount for the service will be the historical payment amount plus 15 percent of the fee schedule amount. On the other hand, if the historical payment amount is more than 115 percent of the fee schedule amount, the payment amount for CY 1992 will be the historical payment amount minus 15 percent of the fee schedule amount. Under section 1848(a)(2)(C) of the Act, as amended by section 4102(b) of Public Law 101-508, special transition rules will apply to radiology services in CY 1992.

Rules for the transition during CYs 1993 through 1995 are set forth in section 1848(a)(2)(B) of the Act. During those years, payment amounts for services subject to the transition provisions in CY 1992 will be paid as a blend of historical payment and the fee schedule.

In CY 1996, payment for all services will be fully based on the fee schedule.

These transition rules are set forth in § 415.42.

3. Other Issues Related to Determining the Initial CF

The statute specifically requires that the budget neutrality determination be made with respect to 1991 outlays. The initial budget-neutral CF based on 1991 outlays is updated by the 1992 update determined with reference to the MVPS. Computation of the initial CF requires predictions for CY 1991 with respect to: (1) Fees for each procedure in each area, consistent with the transition provisions, and (2) the frequency with which each procedure is performed. These predictions are very difficult, given that fee schedule implementation involves not only major changes in Medicare fees, but also simultaneous changes with respect to the uniform definition of services for surgical global fees and medical visits.

These two types of services (surgery and visits) account for more than 70 percent of Medicare payments for physician services. When the uniform definition becomes effective there may be many services that are now paid for in global fees (or which are otherwise not now billed) that will be billed separately under the fee schedule. Conversely, services now billed and paid separately in some carrier areas will no longer be separately billable.

With respect to visits, we need to be able to cross reference the old and new coding of the same service. This process has been termed the "crosswalk." The "visit crosswalk" was used in setting the CF, for determining practice expense and malpractice components for visits and consultations, and for determining transition payment levels.

Physicians and beneficiaries could respond to the implementation of the fee schedule in the following ways:

- Physicians could bill appropriately under our proposed new definitions of services and associated payment conventions for services for which they do not currently bill.

- Beneficiaries could seek additional services because of lower out-of-pocket costs.

- Some physicians could bill for a higher level of services, particularly visits, or furnish more concurrent care, consultations, assistants at surgery, and diagnostic tests under the fee schedule.

Therefore, we considered anticipated responses to price changes, policy standardization, etc., by physicians or beneficiaries in setting the initial CF by using a baseline adjustment for the volume and intensity of services. (For

purposes of discussing this adjustment, we have simply referred to it in this preamble as the "baseline adjustment".) It was essential to consider these factors in order to achieve the budget neutrality required by law. The MVPS alone is not an adequate mechanism to account for anticipated responses.

For physicians predicted to experience a net loss of Medicare revenues, we assumed volume and intensity changes sufficient to offset 50 percent of the loss of Medicare revenues that would otherwise occur. We assumed no change in volume and intensity by physicians expected to experience a net increase in Medicare revenues.

We assumed that most physicians would bill at the fee schedule amount, except for certain physicians who currently bill less than the prevailing charge amount. Specifically, we are assuming in this final rule that those physicians who are predicted to receive net increases in Medicare payments and who have previously been charging less than the prevailing charge will increase their submitted charges by half the difference between their submitted charges and the new fee schedule amount in 1992. Further, we assume that by 1996, this group of physicians will have increased all charges so as to close 90 percent of the gap between their submitted charges and the new fee schedule amount.

Taking all these factors and assumptions into account, and applying the 1.9 percent update factor discussed elsewhere, yields a CF for 1992 equal to 31.001.

4. Future Updates of CF

Beginning in CY 1991, section 1848(d)(2) of the Act requires the Secretary to recommend to Congress by April 15 of each year an update to the fee schedule CF for the following calendar year. Congress may choose to enact the Secretary's recommendation, enact some other update amount, or not act at all. If Congress does not act, the annual update is set according to a "default" mechanism in the law. In accordance with the law, the update will equal the MEI adjusted by the amount actual expenditures for the second previous fiscal year (FY) were greater or less than the performance standard rate of increase for that FY (referred to as the "performance adjustment"). We expect to publish in the *Federal Register* by October 31 of each year a separate notice providing the annual updates and the performance standard rates of increase.

F. Data Used to Develop the Fee Schedule

1. Sources of Data

The primary source of national level claims data used for developing the fee schedule was the Part B Medicare annual data (BMAD) files (Procedure, Provider, and Beneficiary files). Because we wanted to use the most complete data available, we primarily used "aged" 1989 BMAD files for calculating the national CF and for calculating the practice expense and malpractice RVUs.

2. Aging of Data to Reflect 1991 Payment Rules and Expenditures

Because we are required to compute a CF that will provide budget-neutral outlays for 1991, the BMAD files were adjusted to reflect 1991 payment rules. In general this aging process was accomplished by adjusting 1989 and 1990 prevailing charges for changes made by both Public Law 101-239 and Public Law 101-508.

Certain sections of Public Law 101-239 and Public Law 101-508 required data adjustments. For example, we made adjustments for overvalued procedures, designated specialty, radiology reduction, and MEI differential updates. These files were adjusted further to reflect procedure code changes and standardization of payment policies.

G. Definitions

1. Coding of Medical Visits and Consultations

The CPT has adopted new definitions and new code numbers for all visit categories and we have based the physician work RVUs for visits upon these new visit definitions. The new visit codes rely primarily upon the clinical content of the visit to differentiate among levels of care. Most of the new codes indicate the typical amount of time spent by physicians performing the services included in the visit as an ancillary factor to assist in code selection. For example, the definitions of office visits include an estimate of the typical duration of face-to-face time as an ancillary factor.

We based Medicare payment for visits upon the new CPT visit definitions because the new codes enabled us to establish valid physician work RVUs for these services, while the Harvard research showed that the continued use of the old visit codes would result in inequitable payment for these services. Use of the old codes is so variable that we cannot establish valid RVUs for them. The new visit definitions and code numbers are contained in Addendum E.

We have established a crosswalk between the old and new visit codes that we are using for the CF calculation, practice expense and malpractice expense RVU calculations, and calculation of the AHPB.

We have established this cross-walk only to perform calculations required by the statute. We do not mean to suggest that the content of the new descriptors is equivalent or that physicians should follow a similar cross-walk when deciding how to use the new codes.

2. Global Surgery Policy

The concept of a global fee for surgical procedures is a long established concept under which a single fee is billed and paid for all necessary services normally furnished by the surgeon before, during, and after the procedure. Since the fee schedule is based on uniform national relative values, it is necessary to have a uniform national definition of "global surgery" to assure that, nationwide, payment is made for the same amount of work and resources involved in furnishing the specific service.

To assist in this uniform implementation, the CPT Editorial Panel has created four new modifiers (24, 25, 78 and 79) to identify a service or procedure furnished during a global period that is not normally a part of the global surgery fee. For example, a service unrelated to the condition requiring surgery or for treating the underlying condition and not for normal recovery from the surgery may be payable outside of the global fee. A more detailed discussion of the appropriate use of these modifiers appears in the section on "New Global Fee Modifiers."

The following policy describes the services that will be included in our national definition of "global surgery" and paid under the global fee, and the services that will be excluded and paid for separately. The policy is divided into major surgical procedures, and minor surgical and nonincisional procedures.

a. *Major Surgery.* The initial evaluation or consultation by a surgeon will be paid separately from the global surgery package. The pre-operative policy will include all pre-operative visits, in or out of the hospital, by the surgeon beginning the day before the surgery. We will carefully monitor pre-operative billings by surgeons and we will consider lengthening the global pre-operative period if we detect abuses, for example, significant billings for services 2 or 3 days before surgery.

Intra-operative services that are normally a usual and necessary part of a surgical procedure will be included in

the national global surgery policy. The global surgery fee will include all additional medical or surgical services required of the surgeon because of complications that do not require additional trips to the operating room. All medically necessary return trips to the operating room, for any reason and without regard to "fault", will be separately billed and paid for, but at a reduced rate.

The payment level for re-operations to deal with complications will be set at the value of the intra-operative services being performed if there is a CPT code to describe these services. Codes exist to describe re-operations for complications for various body areas. If no code exists, the payment level may not exceed 50 percent of the value of the intra-operative services originally performed. (See discussion on CPT modifier 78.)

A standard 90-day post-operative period will include all services by the primary surgeon during this period unless the service is for a problem unrelated to the diagnosis for which the surgery is performed or is for an added course of treatment other than normal recovery from the surgery. (See discussion on CPT modifiers 24 and 79.) Immunosuppressive therapy following transplant surgery is not included in the global fee and will be paid separately. The global fee will include services such as dressing changes, local incisional care, and removal of operative packs; removal of cutaneous sutures, staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and change and removal of tracheostomy tubes.

Procedures with a 90-day post-operative follow-up period that will be subject to the major global surgery policy appear in Addendum B of this final rule.

b. *Minor surgery and nonincisional procedures.* In addition to the major global surgeries in the Surgery section of the CPT, there are a number of minor surgeries, many of which are designated by a "star" following the procedure code number. These relatively minor surgical services are not traditionally paid using a global surgery policy.

In addition, the surgery section of the CPT also includes diagnostic and therapeutic endoscopic procedures that are frequently performed by nonsurgeons and may or may not involve actual surgery.

For minor surgeries and endoscopic procedures, no payment generally will be made for a visit on the same day in which the procedure is performed.

addition to the surgical procedure or endoscopy procedure unless a documented, separately identifiable service is furnished (see discussion of CPT modifier 25). For example, a visit could properly be billed in addition to payment for suturing a scalp wound if a full neurological examination is made for a patient with head trauma, but billing for a visit would not be appropriate if the evaluation consisted only of identifying the need for sutures and confirming allergy and immunization status. There will be no post-operative period for endoscopy procedures performed through an existing body orifice. Procedures requiring an incision for insertion of a scope (for example, a laparoscopic cholecystectomy) will be subject to either the major or minor surgical policy, whichever is appropriate.

Minor surgeries will have post-operative periods of 0 or 10 days. Those with 10 days will have all post-operative services related to recovery from the surgery during this period included in the fee for the surgery. Services furnished during this period for treatment of the underlying condition will be paid for separately (see discussion of CPT modifier 24). Minor surgeries with a 10-day post-operative period appear in addendum B of this final rule.

3. Defining Geographic Payment Localities Under the Fee Schedule

Under the present customary and prevailing reasonable charge system of payment for physicians' services, a Medicare locality is the geographic area that the carrier uses to determine the prevailing charges for services. There are presently 240 Medicare localities, which were developed by carriers, based on their knowledge of local medical practice and economic conditions.

Section 1848(j)(2) of the Act defines fee schedule areas as Medicare payment localities. However, recognizing the lack of consistency among current localities and the fact that significant demographic and economic changes may have occurred since the existing localities were established, we are reviewing recommendations on the possible reconfiguration of existing localities. One study has been conducted for us by the UI. Also, Congress required in section 8102(d)(6) of Public Law 101-239 that the PPRC conduct a study to determine the feasibility of using some other configuration, such as States or metropolitan statistical areas (MSAs), for payment areas under the fee schedule. Both the PPRC and the UI

recommended that current carrier localities be replaced with alternative payment areas.

We are still examining these studies. The only locality changes we have made at this time are changes to Statewide localities in States where overwhelming support existed among both rural and urban physicians for the change. Because we have received demonstrations of support from physicians in Nebraska, Oklahoma, and Minnesota, those States will be converted to Statewide localities on January 1, 1992 and a single AHPB will be used for the Statewide locality.

Some States expressed interest in converting to a Statewide locality but had not yet provided evidence of overwhelming support within the physician community for the change. These States will, therefore, not be converted on January 1, 1992. In addition, some individual entities such as cities, towns, and counties asked to be moved out of the current locality into another, usually adjacent locality, with a higher GPCI under the fee schedule. We will consider requests for Statewide locality conversions after January 1, 1992. We continue to believe Statewide localities are generally desirable, because they reduce the number of localities, thereby simplifying program administration, and they tend to increase payments in rural areas. Although we have not ruled out the possibility, we generally do not expect to approve requests for other locality changes during the transition, such as moving individual cities or towns, because these types of changes present significant AHPB and transition payment computation problems. Even without conversion to a Statewide locality, many of the large payment variations that currently exist among localities within a State will be substantially reduced by the use of the GPCIs.

Special gap-filling or super localities or provider-specific localities will not exist under the fee schedule. Single providers, such as the Geisinger Clinic in Pennsylvania, and the University of Iowa Physicians (UIP), which are currently treated separately from other physicians in their geographic area, will be included with all other physicians in the fee schedule area where they are physically located. As a result of the Iowa change, we eliminated locality 8, which consisted only of the UIP and placed UIP with all other physicians in locality 1. We then recalculated a new GPCI for the locality.

H. Adjustments to Fee Schedule Payments

1. Site of Service Differential

Services that are primarily performed in office settings will be subject to a payment limit if they are performed in outpatient departments. For these procedures, we will reduce the practice expense RVU by 50 percent. Payment will be the lower of the actual charge or the reduced fee schedule amount.

A national list of procedures subject to the site of service limitation, which are currently performed predominantly (that is, at least 50 percent of the time) in office settings appears in Addendum F of this final rule. The limit will be applied only to the practice expense RVUs and not the entire payment. The limitation on the practice expense RVUs will reflect lower practice costs incurred in the outpatient department. For office-based procedures, we have determined the practice expense RVUs based on charge data from the office only and not charge data averaged across all settings. We have eliminated the current exception for emergency services. However, physicians who bill an emergency room visit under codes 99281 through 99285 will not be subject to the outpatient limit for these services.

2. Professional/Technical Component Services

There are three types of physicians' services that have both professional and technical components. One group is diagnostic and therapeutic radiology services; the second is certain diagnostic tests that involve a physician's interpretation; and the third is made up of physician pathology services. If services are performed in a hospital setting, the physician bills only for the professional component. If a physician pathology service is performed in an independent laboratory, a global bill for both components is submitted.

a. Radiology services. The global RVU will be the sum of the professional component and technical component RVUs. We divided the professional component RVU from the existing radiologist fee schedule into physician work, practice expense, and malpractice components for purposes of rescaling and applying GAFs.

The practice expense RVUs for technical component services will be determined essentially as practice costs are determined for all other physician services. That is, the technical component RVUs under the physician fee schedule will be equal to the estimated average allowances for each

technical component service based on the radiologist fee schedule.

b. *Diagnostic tests*—(1) *General*. Our definition of a "diagnostic test" was based on the following criteria:

- The service is diagnostic as opposed to therapeutic in nature.
- The physician's professional service is separable from the technical component of the test. This means that the professional diagnostic service is not so integrally related to the performance of the test so as to make separation a practical impossibility.

The professional component RVU will be the physician work RVU (generally based on the Harvard study) plus practice expense and malpractice RVUs based on current average allowed charges. The relative value for the technical component will be based on the difference between the average allowed charge for the global service and the average allowed charge for the professional component whenever there is a substantial volume of services billed for either global or professional component services and there is at least a 21 percent difference between the global and professional component average allowed charges. For services not meeting these criteria, an alternate formula will be used. In general, in computing values for this final rule, an alternate formula was used that is based on the actual charge data for the component with the most charge data and an assumption that the technical component is 21 percent of the global services value. Finally, for diagnostic services for which there is no reliable technical component charge data (for example, cardiac catheterization), the RVUs were derived through alternative means.

For services that do not have a professional component (for example, the various audiologic function tests, 92551 through 92589), the RVUs will be based on the average allowance for the service itself. For diagnostic tests without a professional component (for example, audiology and allergy testing), we will classify them as a technical component only service without physician work (subject to the practice expense and malpractice GAFs only).

In the case of psychological testing, we will address the coverage of these services in the proposed rule to be published on the coverage of services furnished by CPs and CSWs. Until this rule is published, we will continue our present policy of covering psychological testing if the service is furnished, for example, by a physician, (including incident-to services), or by a qualified psychologist (whether or not a clinical psychologist).

(2) *Electrocardiograms*. As required by section 4109 of Public Law 101-508, separate payment is no longer made for the interpretation of the following electrocardiogram (EKG) codes if performed as part of or in conjunction with a visit or consultation: 93000, 93010, 93040, and 93042. Payment may still be made for the interpretation of very specialized EKGs under other codes not included within the scope of the statutory provision. We have added .054 work RVUs, .016 practice expense RVUs, and .001 malpractice RVUs to the office visits, office consultations, and emergency visit codes to reflect the work in EKG interpretations. We added .080 work RVUs, .024 practice expense RVUs, and .002 malpractice RVUs to the hospital visit, hospital consultations, and critical care service codes. For NF, nursing home, and home visits, we added .008 work RVUs, .002 practice expense RVUs, and .0001 malpractice RVUs.

(3) *Technical component of cardiac catheterization services*. Cardiac catheterization services, in the past, have been performed almost exclusively in the hospital setting. With some exceptions, only a professional component billing has been necessary for payment to be made to physicians. However, cardiac catheterization procedures can be covered in free-standing facilities if, in consultation with the appropriate Utilization and Quality Control Peer Review Organization (PRO), carriers can determine that the services can be performed appropriately and safely in the facility.

We believe that the number of procedures done in free-standing cardiac catheterization facilities will increase; therefore, there is a need to establish a technical component value for the service. We used data taken from outpatient hospital bills to calculate the estimated cost for cardiac catheterization furnished in the hospital outpatient department and to use these costs as the technical component for cardiac catheterization services.

We reviewed the 16 different cardiac catheterization codes and found that they could be organized into 5 groups of similar procedures. Since very few claims are submitted for many of the codes in each of the 5 groups, we used the 5 groupings in pricing the technical components for cardiac catheterization codes. The following are the codes used within each of the groupings:

Group 1	Group 2	Group 3	Group 4	Group 5
93501	93510 93511 93514	93524 93526 93527 93528 93529	93546 93547 93548 93549 93550	93552 93553

The RVUs for the codes within each grouping are included in Addendum B of this final rule.

(4) *Purchased diagnostic tests*. In accordance with section 1842(n)(1) of the Act (as added by Public Law 100-203), we will eliminate the physician markup for purchased diagnostic tests under the fee schedule.

c. *Physician pathology services*. We established the technical component of physician pathology services as being equal to 15 percent of the 1991 adjusted historical charge.

3. Payment Modifiers

Only modifiers for which we will establish a national payment policy will affect payment. If there is no national payment policy governing the use of a modifier, carriers may not increase or decrease payment based on the presence or absence of that modifier. However, carriers can continue to use local modifiers if they are used for purposes other than payment (for example, utilization or medical review screening). We have not required the use of a modifier for services billed by a physician that are covered as "incident to a physician's service" if the physician does not personally perform the service.

a. *Multiple surgery (CPT modifier 51)*—(1) *General*. If a surgeon performs more than one procedure on the same patient on the same day, we will pay 100 percent of the global fee for the highest value procedure only, 50 percent of the global fee for the second most expensive procedure, and 25 percent of the global fee for the third, fourth, and fifth procedures. Each procedure after the fifth procedure will require submission of documentation and special carrier review to determine the payment amount.

(2) *Endoscopic procedures*. We stated in the proposed rule that the multiple surgery policy might overpay in the case of multiple endoscopic procedures because the higher valued endoscopies already have the value of the basic endoscopy built in, and we would in effect be counting it twice. We used the example of a physician in the course of performing a fiberoptic colonoscopy (CPT code 45378), performing a biopsy on a lesion (CPT code 45380), and removing a polyp (CPT code 45385) from

a different part of the colon. The physician would bill for both CPT codes 45380 and 45385. The value of CPT code 45380 (9.49 RVUs) and CPT code 45385 (12.46 RVUs) already have the value of a diagnostic colonoscopy (CPT code 45378, 8.48 RVUs) built in. Rather than paying 100 percent of 12.46 RVUs and 50 percent of 9.49 or 17.21 RVUs, we will pay the full value of the higher valued endoscopy (12.46 RVUs), plus the difference between the next highest endoscopy (9.49 RVUs), and the base endoscopy (8.49 RVUs), or 1.01 RVUs, for a total of 13.47 RVUs.

(3) *Dermatological surgery.* For certain dermatology services, there are separate CPT codes, which represent that multiple surgical procedures have been performed (for example, CPT codes 11201, 17001, and 17002). For these codes, the multiple procedure rules will not apply. Rather, we are presenting RVUs for each of these codes. For other dermatologic procedures, we believe a 50 percent reduction in the value is appropriate for the second procedure since pre- and post-work and practice expenses will be diminished. Beyond the second procedure, however, since there may not be the same reductions in work effort that are associated with other multiple surgery, a physician may submit a "by report" bill when three or more lesions are removed.

b. *Bilateral surgery (CPT modifier 50).* The bilateral modifier is used to indicate cases in which a procedure normally done on only one side of the body was, in fact, performed on both sides of the body. The CPT identifies surgical procedures that are typically bilateral in nature. For these codes, the bilateral modifier will not result in increased payment.

In the absence of any evidence with respect to the actual difference in work for bilateral procedures, we will continue the historic practice of paying 150 percent of the global fee.

c. *Providers furnishing less than the global fee package (CPT modifiers 54, 55, and 56).* Under the current reasonable charge policy, the sum of all allowances for all practitioners who furnished parts of the services included in a global fee (and who bill using one or more of these modifiers) must not exceed the total amount of the allowance that would have been paid to a single practitioner under the global fee for the procedure. We will continue to pay the same amount for surgical services if they are furnished by several physicians as we would pay if only one physician furnished all of the services in the global package.

We will pay each physician directly for the portion of the global surgery

services furnished to the beneficiary. We believe the surgeon always furnishes the usual and necessary pre- and intra-operative services, and also, with a few exceptions, in-hospital post-operative services. In most cases, the surgeon also furnishes the post-operative office services necessary to assure normal recovery from the surgery. Recognizing that there are cases when the surgeon turns over the out-of-hospital recovery care to another physician, however, we have determined percentages for families of procedures for paying for usual out-of-hospital post-operative care if furnished by someone other than the surgeon. These are weighted percentages based on the percentage of total global surgical work representing office post-operative care from the Harvard survey.

POST-OPERATIVE PERCENT OF TOTAL RVUS BY PROCEDURE FAMILY

Family	Procedure codes	Post-operative percentage
Integumentary	10000-19499	21
Musculoskeletal	20000-29909	21
Respiratory	30000-32999	13
Cardiovascular	33010-37799	8
Hemic and Lymphatic ..	38100-38999	16
Mediastinum	39000-39599	7
Digestive	40490-49999	12
Urinary	50010-53899	17
Male Genital	54000-55980	15
Female Genital	56000-58999	15
Maternity	59000-59899	22
Endocrine	60000-60699	9
Nervous	61000-64999	114
Eye	65091-68899	20
Auditory	69000-69979	8

d. *Physicians who assist at surgery (CPT modifiers 80, 81, and 82).* We will set the payment level for assistants-at-surgery at the lower of the actual charge or 16 percent of the fee schedule amount for the global surgical service as required by law.

e. *Two surgeons and surgical team (CPT modifiers 62 and 66).* For co-surgeons (modifier 62), we will continue the current predominant carrier practice of paying 125 percent of the global fee and dividing the payment equally between the two surgeons. No payment will be made for an assistant-at-surgery in these cases.

For team surgery (modifier 66), we will continue to allow our CMDs to determine the payment amounts for team surgery on an individual basis.

f. *Unusual services (CPT modifier 22) or reduced services (CPT modifier 52).* We will continue to permit carriers to increase or decrease payment for unusual circumstances, based on their review of applicable medical records or other documentation.

g. *Multiple modifiers (CPT modifier 99).* We believe a national policy regarding the application of multiple modifiers is necessary in order to establish nationally uniform and consistent payments. Our uniform national policy will be to apply up to two modifiers. Claims for which additional modifiers may apply will be priced manually by the carriers.

h. *Multiple patients and single patient modifiers on nursing home visit bills (HCPCS Alpha-Numeric modifiers MP and SP).* The multiple patient (MP) and single patient (SP) modifiers are used to identify visits to patients in nursing homes (other than patients receiving covered Part A care in NFs). We will pay for all visits to patients in facilities classified by Medicare and Medicaid as NFs without regard to the number of patients the physician sees at the facility.

i. *Modifiers that will not affect payment levels.* The presence or absence of the following modifiers will not increase or decrease payment levels under the physician fee schedule, although the modifiers may continue to be used for administrative purposes, including utilization reviews.

- CPT modifiers that do not affect payment.
- HCPCS alpha-numeric modifiers that do not affect fee schedule payment amounts.
- Carrier unique local modifiers (HCPCS Level 3 modifiers beginning with the letters w through z).

We will establish, for administrative purposes only, a modifier to identify monitored anesthesia care.

j. *Travel.* Travel is included in the payment for services furnished and thus generally not separately payable. Under very unusual circumstances, however, unusual travel may be billed using CPT code 99082, unusual travel, and may be paid by a carrier after review of sufficient documentation to support the unusual nature of the travel.

k. *New modifiers.* In the sections on global surgery and minor surgery and endoscopies, we state that we will pay: (1) Separately for services or procedures that are unrelated to recovery from surgery during a post-operative period; (2) separately for re-operations because of complications that require a return trip to the operating room; and (3) for a visit on the same day as a minor surgery or endoscopy if documented, separately identifiable services are furnished. The CPT Editorial Panel has established the following four modifiers both to enable us to better implement this policy and also to reduce the documentation and "hassle" factor on physicians.

CPT modifier 24—Unrelated evaluation and management service by the same physician during a post-operative period. This modifier will be used to indicate that an evaluation and management service was performed during the post-operative period that is not related to the prior procedure.

CPT modifier 25—Significant, separately identifiable evaluation and management service by the same physician on the day of a procedure. This modifier will be used to indicate that on the day a procedure or service that is identified with a CPT code was performed, the patient's condition required a significant, separately identifiable evaluation and management service unrelated to the usual pre- and post-operative care associated with the procedure or service that was performed.

Until we acquire some experience with modifier 24 billings, we intend to treat this modifier as informational only and continue to require that documentation be submitted with the modifier before we pay for these services. This will enable us to analyze the frequency with which we could expect to pay for these services and therefore set a standard for future payment based on actual experience. We might consider dropping the "up-front" documentation requirement after we are satisfied that we have sufficient experience to develop criteria to identify excessive modifier 24 billings.

Modifier 25 may be submitted without documentation. Use of this modifier will:

- (1) Allow separate payment for these visits performed on the day of the procedure without the burden of requiring and examining extensive documentation up front;
- (2) Deny separate payment for visits billed without a modifier; and
- (3) Conduct post-payment monitoring on the use of the modifiers to identify potential abusers.

We would *not* expect to see modifier 25 billings if a procedure, for example, a minor surgery or a colonoscopy, was scheduled after an examination during a prior visit. We expect the significant evaluation for the procedure will be performed and paid for as part of this prior visit. We have already added substantial pre- and post-operative work specific to the procedure (record keeping, counseling, prescribing recovery therapy, etc.) into the value for the procedure. Any modifier 25 billings for unrelated evaluation and management services must be for services *not* provided during either the procedure itself or a prior visit.

CPT modifier 78—Return trip to the operating room for a related procedure

during a post-operative period. This modifier will be used, for instance, for complications from surgery, to indicate that another procedure was performed during the post-operative period of a related procedure.

CPT modifier 79—Unrelated procedure by the same physician during a post-operative period. This modifier will be used to indicate that the performance of a procedure or service during a post-operative period was unrelated to the original procedure.

These two modifiers will simplify billing by physicians and enable carriers to:

- (1) Allow separate payment for surgical procedures unrelated to complications from the original surgery that are performed during the post-operative period of another major surgery;
- (2) Allow separate payment for treatment of complications during the post-operative period that requires a return trip to the operating room; and
- (3) Deny separate payment for treatment of complications that do not require a return trip to the operating room and are billed without the modifier.

While the use of these four new modifiers is intended to facilitate claims processing by identifying which services should be paid and which should not be paid, carriers will not automatically assume from their use that all these services are medically necessary and payable. (In the case of modifier 24, documentation must be provided with the claim for the service to be paid.) In using these four modifiers, the physician is certifying that the services meet the requirements for the specific modifier. Through use of the new comparative performance reports and other payment safeguards, carriers will be required to identify any excessive use of these modifiers. Carriers may request additional documentation from physicians disproportionately using these modifiers and may initiate physician audits, if necessary. Any identified abuses could subject physicians to overpayment refund requests, closer prepayment scrutiny, and possibly fraudulent billing penalties.

4. New Physician/Practitioner Adjustment

We will phase-in increases to the fee schedule payment for physicians, independently practicing PTs and OTs, and health care practitioners, who are in their first through fourth years of practice if certain conditions are met (§ 415.40).

a. *Exceptions.* As specified in the statute, we will not apply the new

physician adjustment to primary care services furnished by physicians (as defined in section 1842(i)(4) of the Act) or to services furnished by physicians or PTs or OTs or health care practitioners in a rural area (as defined in section 1886(d)(2)(D) of the Act) that is designated, under section 332(a)(1)(A) of the Public Health Service Act, as a Health Professional Shortage Area (HPSA).

b. *Years of practice.* The "first year of practice" will be the first full CY during the first 6 months of which the physician, independently practicing PT or OT, or health care practitioner furnishes professional services for which payment may be made under Part B plus any portion of the prior CY if that prior year does not meet the first 6 months test (§ 415.40(c)). The second, third, and fourth years of practice will be the first, second, and third CYs respectively, following the first year of practice. These reductions will apply to each physician based on his or her status as a "new physician", regardless of whether the new physician is a member of a uniform charge structure group practice.

c. *Amounts of adjustments.* The payment for the service of a new physician will be 80 percent of the fee schedule amount in the first year of practice, 85 percent of the fee schedule amount in the second year, 90 percent of the fee schedule amount in the third year, and 95 percent of the fee schedule amount in the fourth year (§ 415.40(d)). These percentages are specified in the statute.

5. Participating Physician Differential

Payments to nonparticipating physicians will not exceed 95 percent of the physician fee schedule amount for a service, since the fee schedule legislation retained the participating physician differential.

6. Health Professional Shortage Area Bonus Payment

Under section 1833(m) of the Act, payments in addition to the amounts otherwise payable under Part B are made to physicians who furnish covered services to Medicare beneficiaries in designated HPSAs. Section 6102(d) of Public Law 101-239 amended section 1833(m) of the Act to increase the amount of this bonus payment from 5 percent to 10 percent for services furnished after December 31, 1990. In addition, the amendment broadened the applicability of the bonus to include all designated HPSAs, eliminating the restriction under prior law to Class 1 and 2 areas. These HPSAs, which are

identified by the Public Health Service (PHS) under statutory guidelines, include both rural and urban areas, and bonus payments may be made in both rural and urban areas as of January 1, 1991. Under the statutory authority cited above, the bonus will be applied to payment amounts derived from the fee schedule (or under the transition rules) beginning in 1992. The HPSA bonus is a payment made in addition to any amount payable under the fee schedule.

7. Comparability and Inherent Reasonableness Rules

In accordance with the statute, payments under the fee schedule will not be subject to the comparability and inherent reasonableness adjustments.

I. Limiting Charge on Nonparticipating Physicians

Effective January 1, 1991, the limiting charge replaced the MAAC. The limiting charge continues to reflect a physician's historical actual charge until 1993.

For CY 1991, the limiting charge is the same percentage (but no more than 40 percent for visits and consultation services and 25 percent for other services) above the 1991 prevailing charge for a nonparticipating physician as the percentage by which a physician's 1990 MAAC exceeded the 1990 prevailing charge for a nonparticipating physician (§ 415.46(b)(1)).

For CY 1992, the limiting charge is the same percentage (but no more than 20 percent) above the 1992 fee schedule amount for nonparticipating physicians as the percentage by which the physician's 1991 limiting charge exceeded the 1991 prevailing charge for nonparticipating physicians (§ 415.46(b)(2)).

Beginning January 1, 1993, the limiting charge is 115 percent of the fee schedule amount for nonparticipating physicians (§ 415.46(b)(3)).

III. Summary of Analysis of Comments and Responses

We have presented all comments and responses, for the most part, in the order that the issues appeared in the June 5, 1991 proposed rule. Before each section of comments, we have briefly summarized the proposal that appeared in the proposed rule. If applicable, we cited the specific CFR section in the proposed rule where we proposed to include the provision. For a summary description of the relevant statutory requirements, see section I of this preamble. Even more detailed background information on many issues can be found in the proposed rule (56 FR 25794).

A. Services to be Included in the Fee Schedule

Section 1848(a)(1) of the Act (as added by section 6102 of Public Law 101-239) requires that payment be made under the physician fee schedule for all physicians' services, as defined in section 1848(j)(3) of the Act, including: professional services of physicians; services and supplies incident to physicians' services (except drugs, which we proposed to exclude); outpatient physical and occupational therapy; diagnostic X-ray and other diagnostic tests; and X-ray, radium, and radioactive isotope therapy, including materials and services of technicians (see § 415.2, definition of "Physicians' Services").

1. Limited Licensed and Nonphysician Practitioners—General

We proposed to apply the physician fee schedule to optometrists, dentists, oral and maxillofacial surgeons, podiatrists, and chiropractors when they furnish specific services for which the law considers them to be physicians.

Physical, occupational, and speech therapy services that are covered when furnished by a provider of services (for example, a hospital, and SNF) will not be affected by implementation of the physician fee schedule. Physical and occupational therapy services furnished in an independent practice will be assigned a relative value and paid under the physician fee schedule as specified in the statute.

Under the statute, prevailing charges for assistant-at-surgery services furnished by PAs, will be limited to 65 percent of the physician fee schedule amount. Services furnished in a hospital, other than assistant-at-surgery services, will be limited to 75 percent of the physician fee schedule amount. All other PA services will be limited to 85 percent of the physician fee schedule (see § 415.48).

The need to compute customary and prevailing charges for services by PAs and NPs will continue after implementation of the physician fee schedule, because section 6102(f)(4) of Public Law 101-239 only limits PA and NP payment amounts by the specified percentages of the fee schedule, but does not replace the current reasonable charge system for these services.

The law also limits prevailing charges for services of NPs furnished in SNFs or NFs to 85 percent of the physician fee schedule amount (see § 415.54). For services of NPs and CNSs furnished in rural areas as defined for the hospital PPS, the allowed amount will be limited to the lower of the actual charge or 75

percent of the physician fee schedule amount for services furnished in a hospital; and will be limited to the lower of the actual charge or 85 percent of the physician fee schedule amount for all other services.

Under the new fee schedule law, payment for NMs will be limited to 65 percent of the physician fee schedule amount (see § 415.50).

Two types of services can be independently billed by CPs: Therapeutic services and diagnostic tests. We proposed that diagnostic tests furnished by CPs be paid under the physician fee schedule like all other fee schedule services. (Other diagnostic services and therapeutic services of CPs will be paid under a separate rule, which is still being developed.)

Under the statute, allowed amounts for the therapeutic services of CSWs will be limited to 75 percent of the allowed amounts under the fee schedule established under section 1833(a)(1)(L) of the Act for the services of CPs (§ 415.58).

[Separate RVS for Nonphysician Practitioners]

Comment: Commenters stated that we should develop a separate RVS to capture the work of nonphysician practitioners and pay them accordingly. For example, nursing groups commented that while they realize that payments for the services of NPs and CNSs are generally limited by sections 1833(a)(1)(M) and 1833(r) of the Act to a certain percentage of the amount of payments to physicians, they would prefer to have their payments based on a study of the resources involved in furnishing the services.

Response: We have no plans to develop a separate RVS for nonphysician practitioner services because various sections of the Act require that payment for these services be based on a percentage of the payments made to physicians.

[Inclusion of Limited Licensed Practitioners in Physician Fee Schedule]

Comment: Some commenters stated that only individuals with MD or DO degrees should be considered to be physicians. These commenters opposed our proposal to pay physicians who are not MDs or DOs the same amounts as will be paid to other physicians specified in the law. They also believe the fee schedule was not originally developed to be applied to non-MDs and that it has no bearing or relevance to services performed under their care.

For example, commenters (many of whom were ophthalmologists) objected

to our proposal to pay optometrists and MDs the same amount when they bill the same code because the commenters believe the services of optometrists represent different resource inputs and therefore optometrists should not be paid the same as MDs for the services they furnish. The commenters indicated that the PPRC has found that optometrists are currently paid 10 to 20 percent less than MDs for office visits, and these commenters believe that there is no justification in law or current practice to pay optometrists at the same payment levels as MDs. These commenters also stated that the scope of services furnished by optometrists varies from State to State, compared to the scope of practice for MDs, which is nationally recognized. Lastly, they stated that the cost of resources for an MD is greater than for an optometrist and must be recognized in a resource-based payment system. The commenters proposed that we either apply a percentage reduction to all optometrists' services or establish separate codes or RVUs for their services to reflect their reduced value.

Response: We have not revised our policy as a result of these comments. Section 1848(c)(6) of the Act prohibits us from using different relative values or CFs for different physician specialties. Moreover, section 1861(r) defines "physician" for purposes of the Medicare program. That definition considers optometrists, podiatrists, dentists, oral surgeons, and chiropractors to be "physicians" within the limitations specified in the statute. We explored whether the services furnished by limited licensed practitioners were equivalent to those furnished by MDs and DOs. We were not convinced that there were any differences in the services furnished. (Chiropractor services covered by Medicare constitute a unique situation, which is discussed below.) See comments and responses on RVUs for limited licensed practitioner services for more discussion of this subject.

[Relative Payments for Physicians and Nonphysician Practitioners]

Comment: Some commenters stated that nonphysician practitioners should be paid at the same rates as physicians if they furnish identical services. Other commenters stated that nonphysician practitioners should be paid at a percentage of the payment made to physicians because they offer a lesser level of training, education, and skill when they furnish a service.

Response: The Act specifies that certain nonphysician practitioners must be paid at prescribed percentages of the

amount that would be paid to a physician if the physician furnishes the service. These include PAs, NPs, CNSs, certified NMs, and CSWs. We cannot change the payment percentages announced in the proposed rule, because the percentages merely reflect the statutory requirements.

[Effects of Fee Schedule on PTs and OTs]

Comment: Independently practicing PTs and OTs, whose payments are set at the payments to physicians for the services they furnish, objected to the reduction in their payments caused by the volume response and transition adjustments to the fee schedule.

Response: Section 1848(j)(3) of the Act includes the services of PTs and OTs in the definition of "physician services" for purposes of the fee schedule, and therefore their payments are affected by the CF adjustments and other adjustments needed to establish budget neutrality.

[Non-MD Services not Studied by Harvard]

Comment: Some services such as chiropractic, physical therapy, and occupational therapy, were not part of the Harvard study. Commenters questioned why payments for these services will be adjusted under the fee schedule.

Response: While these practitioners and their services were not included in the Harvard study, section 1848(j)(3) of the Act specifically includes them in the definition of "physicians' services" under the fee schedule. Consequently, we determined relative values for their services as discussed elsewhere in this preamble.

Payments for these services were adjusted along with all other physicians' services to comply with the budget-neutrality requirement in the law. This adjustment applies equally across-the-board to all services under the fee schedule.

[Reason not to Exclude Certain Nonphysician Services from the Fee Schedule]

Comment: Commenters questioned why the authority to exclude certain services from the fee schedule was not used to exclude services furnished by PTs, OTs, and tests done by nonphysicians, such as audiologists.

Response: Even though the law permits the Secretary to specify services to be excluded from the fee schedule, section 1848(j)(3) of the Act contemplates that all physicians' services that are currently paid on a reasonable charge basis be included

under the fee schedule. The definition of "physicians' services" set forth in section 1848(j)(3) clearly includes the above-mentioned services. Since the above-mentioned services have, like services furnished by physicians, historically been paid on a reasonable charge basis and therefore are subject to the payment inequities in that system, we see no convincing reason why they should be excluded from the fee schedule.

[Effects of Fee Schedule on Certain Nonphysician Practitioners]

Comment: Some nonphysician practitioners whose payments are tied to the fee schedule (for example, physician assistants) commented that their payments per service should not be reduced because of the transition and volume response assumptions we made. They stated that this is an unintended effect of the fee schedule because nonphysician practitioner payment is a percentage of the physician payment. Since the physician payment is reduced as a result of the volume response and transition requirements, nonphysician practitioner payment is similarly reduced.

Response: As we indicated above, various sections of the Act relate payment for these nonphysician practitioner services on the payment made to a physician furnishing the same service. Hence, adjustments to the fee schedule CF will affect payments to nonphysician practitioners.

[Payment for Clinical Psychology Services]

Comment: Commenters questioned how clinical psychology services will be paid.

Response: Therapeutic services of CPs are currently paid under their own fee schedule, which was initially established at 80 percent of the prevailing charges of psychiatrists. As mentioned in the proposed rule (56 FR 25798), we are developing a separate rule for paying for these services. Until that rule is finalized, the current psychology fee schedule will remain in effect. As also mentioned in the proposed rule, diagnostic testing services of CPs will be paid under the physician fee schedule. The payment amount for psychological testing will be the same whether the service is furnished by a qualified psychologist or by a physician.

[Payment for Psychological Testing]

Comment: One commenter supports our proposal to pay the same amount for diagnostic tests covered under section

1861(s)(3) of the Act regardless of whether performed by a physician or a CP. However, the commenter recommends that the RVUs be based on a study of the resources used by the primary providers of the tests, CPs, as well as psychiatrists, not on charge data.

Response: Harvard did not study the services of nonphysician practitioners. We agree that actual resource data is preferable to charge-based extrapolations under a resource-based fee schedule. However, the charge data on psychological testing (CPT code 90830) did include charges from independently practicing psychologists as well as from psychiatrists and others such as clinics and neurologists. The average charges from all these sources were similar. Moreover, it is likely that a significant portion of the testing billed by psychiatrists and clinics was performed by psychologists and billed as "incident to" services.

[Payment Rules for Mental Health Services]

Comment: A number of commenters expressed concern about the payment levels, coding, and coinsurance requirements for psychologists' and CSW services. Psychologists commented that mental health services should be paid at the same rate whether performed by a psychologist or a psychiatrist. Psychiatrists commented that their services are materially different than those furnished by psychologists and should be paid at a higher rate. Others commented that the payments should be resource-based and thus should reflect any differences in resource costs between psychologists and psychiatrists.

Response: The proposed psychologist fee schedule has not yet been published.

At the time it is published, we will consider all timely public comments we receive. The special coinsurance requirements for outpatient mental health services have been required by the law since its inception, and we have no authority to change them.

[Optometrists Furnishing Post-Surgical Care]

Comment: Ophthalmological societies and individual ophthalmologists commented that we should not pay optometrists for furnishing post-operative follow-up care to cataract surgery performed by ophthalmologists.

Response: It is not uncommon for an optometrist to refer a patient to an ophthalmologist for possible cataract surgery and for the ophthalmologist then to send the patient back to the optometrist for the post-operative

follow-up care. Ophthalmological societies take the position that good medical practice dictates that the surgeon should also furnish the post-operative care and discourage referrals to optometrists for post-operative care. These societies have many times in the past asked us to prohibit payments to optometrists in this situation. Our response has always been and continues to be that we are required by law to pay for these services if they fall within the scope of the services that the optometrist is allowed to perform under State licensure requirements. If ophthalmological societies believe that optometrists should not furnish post-operative care, the societies themselves should set these standards for their own members.

[Pay Chiropractors for X-Rays]

Comment: Some commenters objected to the absence of Medicare payment for the performance and analysis of the x-ray that Medicare requires be performed as a prerequisite to Medicare coverage of chiropractic manipulation of the spine. They stated that chiropractors should be paid the same amount as Medicare pays DOs for the x-ray, the diagnosis of the subluxation, and the manipulation. Commenters stated that chiropractors receive more training in x-ray, diagnosis of skeletal abnormalities, and manipulation than DOs and should be paid at the same or a higher rate because they furnish a higher quality of manipulation. They stated that the proposed payments for chiropractors would eliminate access to chiropractic care for Medicare patients.

Response: We have not changed the requirements for coverage of chiropractic care. Section 1861(r) of the Act considers chiropractors to be physicians for purposes of Medicare coverage only when they perform manipulation of the spine to correct a subluxation demonstrated to exist by x-ray. Chiropractors, under Medicare law, are not physicians for purposes of performing or interpreting an x-ray or for purposes of making a diagnosis based upon the x-ray. Therefore, we cannot pay for a chiropractor's interpretation of an x-ray or resulting diagnosis.

[Pay Chiropractors for Physical Therapy]

Comment: Commenters believe chiropractors should be permitted to perform physical therapy and be paid for that service under Medicare.

Response: Coverage of chiropractic services is limited to a single code, manipulation of the spine. The law restricts coverage of physical therapy to

a licensed PT or to services furnished "incident to a physician's service."

2. Certified Registered Nurse Anesthetists (CRNAs)

With the exception of certain rural hospitals, payments for the services of CRNAs are made under the CRNA fee schedule, which was designed so that it is similar to the payment system for physician anesthesia services. Payment for services would be made by multiplying the appropriate CRNA CF by the base and time units for the procedure. Under the initial CRNA fee schedule, we developed State-specific CFs for both medically and non-medically directed CRNAs; Public Law 101-508 specified CFs for the CRNA fee schedule for services furnished after December 31, 1990. The CRNA CFs may not exceed the CF applicable to anesthesiologists in the same locality.

Since we proposed to eliminate time as a separate payment element for physician anesthesia services, we proposed the same policy for CRNA services furnished beginning January 1, 1992. We also proposed to apply an adjustment factor to the payment amount for nonmedically directed CRNA services to assure that payments are not in excess of the payment for physician anesthesia services. In the proposed rule, we also requested comments as to how and whether the relationship in payments between medically directed and nonmedically directed CRNA services should be preserved (that is, the CRNA CF for medically directed services was set by Congress at 70 percent of the nonmedically directed rate).

[Use of Same RVUs for CRNA and Physician Anesthesia Services]

Comment: Virtually all commenters favor the proposal to use the same relative values to determine payments for both CRNAs and physician anesthesia services, because this simplifies bill preparation and claims processing.

Response: We will continue to use the same relative values for both CRNA and physician anesthesia services. This means that the base units used under the uniform relative value guide for personally performed physician anesthesia services will also be used for anesthesia services furnished by CRNAs. In addition, time units for CRNA services will be determined on the basis of one time unit for each 15 minutes of anesthesia time.

[Payments Based on Actual Time]

Comment: Some commenters proposed that no adjustment factor be applied to the payment amount for nonmedically directed CRNA services to assure that payments are not in excess of the payment for a procedure personally performed by an anesthesiologist. Instead, these commenters suggested that a modifier be used to signify the procedure is a nonmedically directed CRNA service and that the procedure be paid at the same rate as the anesthesiologist.

The commenters also recommended that medically directed CRNA services be paid at a level *equal* to 70 percent of the physician anesthesia fee schedule amount, instead of being *limited* by 70 percent of the physician anesthesia fee schedule payment amount. In essence, the commenters suggested that CRNA services be paid at 70 percent of the physician anesthesia payment amount without regard to whether the CRNA payment amounts are less than 70 percent of the physician anesthesia payment amounts. This would effectively raise payments if, for example, for a given payment area, the CRNA payment amount is less than 70 percent of the physician fee schedule amount.

Response: Since we are retaining temporarily actual time for anesthesia services, we will continue temporarily to determine payment for anesthesia services furnished by CRNAs on the basis of allowable base and time units and the appropriate CRNA CF. For 1992, the base medically directed and nonmedically directed CRNA CFs are \$10.75 and \$15.75, respectively. These CFs are divided into a work, practice expense, and malpractice expense component based on the anesthesia specialty weights. Each of these components is multiplied by the applicable GPCI and the amounts summed. The resultant amount is the area-specific medically directed or nonmedically directed CRNA CF. As provided for in the law, the CRNA CF for nonmedically directed services will be limited by the physician anesthesia CF in the locality. We will neither limit the CF for medically directed CRNAs to 70 percent of the anesthesiologist's CFs nor raise any CFs to this level. We will, however, consider whether a legislative change should be proposed to preserve the 70 percent relationship between medically directed and nonmedically directed contemplated in the statute.

[Nonmedically Directed CRNA Services]

Comment: Currently, under the CRNA fee schedule, CRNAs are not paid

separately for specialized care services furnished to patients regardless of whether this is furnished separately or in connection with the anesthesia service. Some commenters asked that CRNAs be paid separately, consistent with the policy for anesthesiologists, for specialized care services, such as the insertion of Swan-Ganz catheters. Some commenters also requested that CRNAs be paid a pre-anesthetic initial evaluation/consultation fee if the surgery is not performed.

Response: We will recognize separate payment for the same specialized procedures furnished by CRNAs or anesthesiologists, subject to the conditions listed below. Also, these services can be separately recognized regardless of whether they are furnished as a single service or in connection with the physician anesthesia service.

We recognize that the anesthesia service furnished by the CRNA can be medically directed or nonmedically directed. Specialized procedures are medical or surgical procedures not anesthesia procedures and are, therefore, not subject to the general medical direction rules. If a CRNA typically furnishes anesthesia services without medical direction, we assume that the CRNA furnishes the specialized care service without the involvement of an anesthesiologist. Payment will be determined on the basis of the usual physician fee schedule payment rules. If a CRNA typically furnishes anesthesia services under medical direction, we assume that the anesthesiologist will furnish the specialized care service and not recognize any payment for the CRNA's involvement with the specialized procedure.

We will also recognize separate payment if a nonmedically directed CRNA furnishes a pre-anesthetic evaluation/consultation service and the patient does not undergo surgery. Payment for this service will be made in accordance with the general physician fee schedule payment rules. We will not recognize separate payment in medically directed CRNA cases, because we will assume that the anesthesiologist will have furnished this service.

3. Services of Physicians to Patients in Provider Settings and Services of Teaching Physicians

Under the proposed rule, direct patient care services of provider-based physicians, including those in teaching hospitals with the exception of hospitals under the cost-election provision, would be paid for under the physician fee schedule on the same basis as other physicians' services. The proposed rule

also stated that attending physician criteria for teaching physicians would remain in effect under the physician fee schedule.

[Billing for Each Physician Service]

Comment: The commenters currently use the per diem method to bill for physicians' services. They stated that they are not equipped to identify and bill for each physician's service and to do so will be an undue hardship on them. Under the per diem payment method, payment for services of physicians to patients in provider settings may be made directly to the provider on the basis of a single per diem rate if the provider has a uniform all-inclusive rate for services to patients. This method is mainly used by government hospitals.

Response: Section 1848(a)(1) of the Act states that physicians' services currently paid on a reasonable charge basis must be paid under the fee schedule beginning in 1992. The per diem method, except when used in a qualified teaching facility under the cost election, is a method of calculating reasonable charges and is authorized under the reasonable charge sections of current law and regulations. We therefore believe we are required to make payment based on the fee schedule and not on this method of reasonable charge billing. Although we recognize that converting to itemized billing will require some effort and expense, many conversions have been done in the past. Further, with existing computer billing services the effects of this conversion should be minimal. Also, we do not believe it is unreasonable for an entity paid under the fee schedule for physicians' services to identify the services for which payment is being requested.

4. Payment for Supplies, Services, and Drugs Furnished Incident to a Physician's Service

a. *Supplies.* Under the proposed rule (§ 415.32(a)), office medical supplies, except for drugs and specified supplies, would be considered to be practice expenses to the physician, and payment would be included in the practice expense portion of the payment for the medical or surgical services to which they were incidental.

We proposed to establish a separate fee schedule allowance for the following expensive supplies: Lumbar puncture trays, thoracentesis trays, cystoscopy trays, surgical trays, catheter insertion trays, bone marrow aspiration trays, and venous access catheters. We requested comment on this approach

that could be of assistance in establishing payment amounts for these items.

[Separate Payment for Medical Supplies]

Comment: Some commenters stated that bundling payment for supplies into the service would result in inadequate payment for the supplies when they are used and improper increases in payment for services that use no supplies because the amount and cost of supplies used for different services varies so much. Some commenters stated that bundling payment into the service would result in physicians requiring the patient to buy the supplies and bring them to the office when the service is furnished.

Some commenters stated that carriers should have the discretion to pay for additional supplies. Some commenters suggested that we develop specific criteria for determining whether a supply should be subject to a separate fee schedule allowance. According to these commenters, if the supply cost represents a disproportionate share of the RVU, the supply should be separately payable. Other commenters recommended that we expand the list of supplies to include reusable trays that include highly specialized instruments "which are far beyond the supplies incident to practice." Some commenters listed specific supplies that they believe should be separately payable. Other commenters expressed support for our proposal but urged us to base payment on accurate cost data. Commenters believe, however, that implementation of this policy should not be delayed in the event we do not have sufficient data to determine a national payment. These commenters prefer that we implement this policy and make adjustments in the fee schedule amounts as better data become available.

Response: We acknowledge that some carriers have paid separately for these supplies in the past. We believe, however, that the practice expense portion of the payment for a service should include the payment for routine office supplies, including medical supplies except those specified in addendum G of this final rule.

We will allow, however, a separate payment for supplies for facility-based services that we designate if those services are performed in the office. Specifically, in consultation with our medical advisors, we developed the following policy for this final rule:

- We have established a practice expense RVU of 1.0 to pay for supplies that are used incident to a physician's service but are generally not the type of routine supplies included in the practice

expense RVU. We are not precisely specifying each supply item that could receive extra payment, nor do we claim that the payment precisely covers direct supply costs incurred for any given service. We believe, however, the extra payment serves to partially offset extra costs incurred by physicians if they furnish certain surgeries in the office. We believe there are some offsetting savings if physicians do these services in their offices including time, travel, and convenience. Because we do not believe supply costs vary significantly between geographic areas, the GPCI will not be applied to the same practice expense RVU to determine the payment for supplies. We expect to consider this issue further in the future and may establish more categories of supplies—each with a different practice expense RVU to reflect differences in supply costs associated with performing different procedures. This would generally be done in a budget neutral way consistent with the process for revising other RVUs.

- We have established a list of facility-based procedure codes in addendum G of this final rule for which we will pay separately for supplies if the service is furnished in the office. The physician will bill for a supply code (A4550) along with the procedure. Physicians will also have to report the office as the place of service where the services are furnished on the claim.

The following criteria were used to establish the list of procedures in addendum G of this final rule:

- The procedures, in appropriate circumstances, can safely be performed in the office setting. We made this determination based on the clinical judgment of our medical advisors and an analysis of our Medicare charge data. We excluded procedures that our Medicare charge data indicated were performed in the office less than 5 percent of the time.

- Furthermore, we deleted procedures with fewer than 1,000 allowed services from our list because we were not able to fully analyze low value procedures to determine if they appropriately could be performed in office settings or are performed in office settings less than 5 percent of the time.

- The procedure is not routinely provided in the office setting already. If a procedure was performed in the office 50 percent or more of the time, we considered this procedure to be routinely performed in the office setting and not eligible for a separate supplies payment because the practice expense RVU generally already reflects these costs.

- The procedure requires specialized supplies that are not used routinely and are generally disposable.

- Treatment of fractures and dislocations were excluded because splints, casting supplies, and surgical dressings are separately payable under the reasonable charge payment methodology under section 1861(s)(5) of the Act.

- Repairs of lacerations were excluded because, in the judgment of our medical advisors, these procedures do not require supplies that are beyond those routinely available in physicians' offices.

We computed these payments in a budget-neutral manner by factoring them in when we computed the CF.

[Separate Supply Allowances]

Comment: Some commenters stated that all procedures performed in the office should be subject to separate supply allowances—not just those procedures performed predominantly in the ambulatory surgical center (ASC) or hospital setting. Some of these commenters believe that the fee schedule does not account for supply costs because Harvard studied only physician work. According to other commenters, the supplies needed to perform a procedure will be the same in all sites and should be paid for separately. If a list is to be developed, these commenters suggested that it be published in the **Federal Register** for comment. Some of these commenters provided a list of procedures that should be subject to an additional supplies payment. Other commenters provided a list of procedures and the associated supplies that they believe should be subject to additional payment.

Response: For most services the fee schedule accounts for supply costs in the practice expense component of the RVU, which is based on average allowed charges. The average allowed charge for a facility-based procedure reflects the weighted average charge across all sites. If the service is performed predominantly in an ASC or inpatient hospital, the average allowed charge will primarily reflect the charges in those settings. We believe some of these services are safe to perform in the office setting but the practice expense component of the RVU for facility-based procedures does not reflect the costs of certain expensive supplies used to perform the procedure. Therefore, only in these instances, we will make a separate payment for supplies.

We listed examples in the proposed rule of the types of procedures for which we proposed to allow an additional

payment for supplies. As stated above, Addendum G lists the procedures for which we will pay separately for supplies based on a practice expense RVU of 1.0. We will continue to consider this issue further, and we will propose any revisions to this policy in the **Federal Register** for public comment.

[Exclusion of Supply Payments]

Comment: Some commenters believe supply payments should be excluded from the MVPS because payment would only cover costs.

Response: For the purposes of determining the MVPS, section 1848(f)(5) of the Act defines "physicians' services" to include "other items or services * * * that are commonly performed or furnished by a physician or in a physician's office." As the supplies that will be separately payable under this policy will be commonly furnished in a physician's office, they will meet the definition of "items and services" that must be included in the MVPS.

[Maintenance of Equipment for Diagnostic Tests]

Comment: Some commenters suggested that we make separate payment to cover the costs of using and maintaining equipment necessary for specific diagnostic tests. These commenters believe the Medicare program would benefit by paying a capital allowance for procedures that are routinely performed in the more extensive hospital setting. If we determined that the practice expense RVU does not include the per procedure cost of equipment, these commenters suggest that we should provide a separate capital allowance.

Response: As we have stated elsewhere in this preamble, the capital costs of furnishing diagnostic tests are typically recognized through payment for a technical component service. Therefore, with regard to diagnostic tests, we believe the technical component payment compensates the provider for use and maintenance of equipment. With regard to other physicians' services, to the extent that the average allowed charges reflect the costs of purchasing and maintaining equipment, the capital costs associated with equipment will be compensated through the practice expense RVU.

[Formal Mechanism for Updating the List of Supplies]

Comment: Some commenters suggested that we establish a formal mechanism for updating the list of supplies that are subject to separate payment. These commenters believe we should create an advisory panel

comprised of HCFA staff, physicians, distributors, and manufacturers that are accessible to the public for this purpose. According to these commenters, updates to the list should be made through carrier instructions and program memorandum—not through regulation. Other commenters believe the list of supplies subject to additional payment needs to be carefully defined to ensure consistent implementation and that each carrier is paying for identical items. These commenters recommend that we adopt a standard product numbering and classification system for all supplies subject to this policy.

Response: As we stated earlier, we will not try to precisely identify the specific supply items that will be separately payable. Rather, our supplies payment is intended to offset the costs of certain supplies that are not routine and are not already included in the practice expense RVU. Again, we will continue to examine this issue to determine whether additional supply categories should be established.

[Chemotherapy Administration Supplies]

Comment: Some commenters stated that some carriers pay separately for supplies used in chemotherapy administration. These commenters oppose distributing the dollars paid for supplies across all of the practice expense RVUs because they believe the average allowed charge will understate the cost of furnishing chemotherapy administration in areas where supplies are paid for separately. According to these commenters, we should calculate the practice expense RVUs based on average allowed charges that bundle supply payments with chemotherapy administration services. Similar comments were received to indicate that allergists typically bill Medicare separately for medical supply items used in the office practice of allergy and immunology.

Response: We reviewed the national HCPCS codes that are available for these services to determine the extent of separate billings for supplies for these services. There are generally no national HCPCS supply codes that relate to specific services such as chemotherapy administration or to allergy and immunology. We have looked at all relevant general supply codes, however, and estimate that total Medicare allowed charges for supplies billed by physicians were about \$35 million. While we were unable to determine the proportion of these supply costs attributable to allergy and chemotherapy, we believe the overwhelming proportion of these

charges is associated with surgical procedures.

We also reviewed local codes that could have been used to describe chemotherapy and allergy and immunology supplies. We found that only three carriers had any supply codes that were specific to these services. As a result of this review, we believe even if we were able to precisely allocate supply billings to specific services for the purpose of establishing practice expense RVUs, the resulting increases would be negligible. Since we could not determine the extent of billings for chemotherapy and allergy and immunology supplies and other specific services, we did not make any adjustments to the practice expense RVUs for these codes. These supply billings, however, were included in establishing the overall budget-neutral CF.

b. *Services.* We proposed that services of nonphysicians that are covered incident to a physician's service would be paid under the fee schedule as if the physician had furnished the services (§ 415.32(b)).

[Payment for Nonphysician Employee Services]

Comment: Some commenters supported our proposal to pay physicians for the services of nonphysician employees as if the physician had furnished the services. They stated that the RVUs assigned to these services reflect the resource cost involved, including the extent of training required and that to reduce payment further through use of a provider modifier would undermine the fee schedule. Some commenters stated that the same level of payment should be applied because this payment would compensate the physician for nonbillable time spent training and supervising the nonphysician; it would compensate for the professional liability that the physician assumes in the work of the nonphysician; and to do otherwise would create two scales of payment, one for the physician and another if the service is not performed by the physician.

Other commenters objected to our proposal to make payment for the services of nonphysicians (and lesser medical personnel) that are "incident to a physician's service" at the physician payment level if the services require little or no physician work. They proposed that nonphysician practitioners be paid at a percentage of the physician payment amount regardless of whether services they were furnishing "incident to" a

physician's service were covered under the separate provisions relating to nonphysician practitioners. They noted that it would be inconsistent to pay for the services of a nonphysician practitioner at a reduced percentage if the service is furnished in a nursing home as required by other provisions of the law, but to pay at the full payment amount for a nonphysician practitioner if services are furnished in a physician's office under the supervision of a physician.

They recognized, however, that this policy might lead to payment for the services of nurses, and other medical personnel at the physician rate, while nonphysician practitioners (who may have higher levels of training and skill) are paid at a lower rate. To remedy this possible problem, they proposed to apply physician fee schedule amounts to services furnished personally by physicians, and that payment for services rarely furnished by physicians (such as injections and simple dressing changes) be "primarily comprised of practice expense and malpractice expense." They proposed that we establish criteria that determine which services should be paid on the basis of practice expense and malpractice expense (services that physicians rarely perform) and which services should be paid on the basis of physician work, practice expense, and malpractice expense.

Some commenters indicated that services "incident to a physician's service" fall into two categories:

- Services that require physician work in which a nonphysician (for example, PA or NP) substitutes for the physician in furnishing the work; and
- Services that are ancillary to the work of the physician and do not require the advanced training and skill of a physician or a nonphysician practitioner, but which can be and are typically performed by a registered nurse (RN), licensed practical nurse (LPN), or health assistant (for example, injections and dressing changes that can be performed by an RN or LPN).

The commenters stated that nonphysician practitioners who substitute for physicians should be paid the same amount as physicians for the services they furnish regardless of whether the service is "incident to" a physician's service or under the nonphysician practitioner coverage provisions, but that when a nonphysician employee of a physician furnishes an ancillary service that does not require the skills of a physician, the payment to the physician should not include the physician work portion of the payment.

Some commenters supported the proposed use of a modifier to identify services furnished by a nonphysician practitioner or nonphysician, but covered as "incident to" a physician service. Other commenters opposed the proposed use of a modifier to identify services furnished by a nonphysician incident to a physician's service when the physician has no contact with the patient. They indicated that this requirement would lead to confusion, paperwork burden, and would invite circumvention, such as a physician stopping by to ask how the patient is feeling.

Response: While we respect the arguments made in regard to this issue, we intend to continue our longstanding policy on "incident to" services as part of the physician fee schedule for the time being. At this time, we have no data on which "incident to" services are being furnished, the frequency of these services, or who is performing them. We believe this information would be essential in order to establish criteria. Moreover, if we established these criteria, we would be concerned whether the statutory methodology for calculating practice expense and malpractice expense would result in appropriate payment for the resources invested in the nonphysician staff who are furnishing these services. We believe this issue of "incident to" services needs to be carefully considered within the context of payment for practice expenses. In addition, at this time we have decided not to require the use of a modifier to indicate that the physician is billing for a service furnished by a nonphysician practitioner or other nonphysician without a physician encounter. We will continue to consider this issue and may selectively test the use of a modifier to determine to what extent physicians bill for services totally furnished by nonphysician employees under the "incident to" provision.

[Physical Presence of a Physician]

Comment: Commenters objected to the current requirement that the physician be physically on the premises in order for the services of a nonphysician employee to be billed as "incident to" a physician's service.

Response: This requirement is a longstanding coverage requirement for which no change was proposed in the proposed rule and for which no change has been made in this final rule.

c. *Drugs and injections.* We proposed to use a standard method to pay for drugs (\$ 415.34). We proposed to base payment for drugs on 85 percent of the national average wholesale price of the

drug. For high volume drugs, we proposed that payment be limited to the lower of the estimated actual acquisition costs as determined by us and specified in instructions to carriers, or 85 percent of the national average wholesale price (AWP) of the drug.

When a physician provides a visit or other service to a beneficiary and, during the encounter, the beneficiary receives an injection, we proposed no additional payment would be made for the injection. The drug would be paid separately as discussed above.

Under the proposed rule, in unusual circumstances if no evaluation and management service is furnished and the physician bills for the injection, payment for the injection would be based on the RVUs for the applicable injection code.

We proposed to pay separately for chemotherapy infusions and chemotherapy administration into specialized body cavities.

[Payment for Drugs]

Comment: We received a great many comments on this issue, primarily from oncologists indicating that our 85 percent standard was inappropriate. The thrust of most of the comments was that many drugs could be purchased for considerably less than 85 percent of AWP—particularly multi-source drugs—while others were not discounted. Other commenters suggested that, while pharmacies and perhaps large practices could receive substantial discounts on their drug purchases, individual physicians could not. The bulk of the comments suggesting alternatives to our proposal indicated that the amounts paid should be based on actual or estimated acquisition costs.

Also, a number of comments from the oncologists indicated that we should use an add-on to cover the cost of breakage, wastage, shelf-life limitations, and inventory costs associated with chemotherapy agents. Some commenters also suggested that this add-on payment was needed to account for shortfalls in chemotherapy administration payments. Without adequate compensation, commenters suggested, many physicians would perform the service in hospital outpatient departments at substantially higher costs. Also, some commenters suggested that physicians would refuse to supply the drugs to patients, forcing patients to purchase the drugs themselves and bring them to the physician's office to be administered. In the latter case, the drugs would not be covered by Medicare since the physician did not incur any costs for the drugs.

Response: After considering all of the comments on this issue, we have decided to modify the proposed policy. Payment for drugs would be based on the lower of the national AWP or the Medicare carrier's estimate of actual acquisition costs. Since there can be many wholesale prices listed for each drug because of multiple sources for the drug, we are defining the national AWP as the median price for all sources of the generic form of the drug. Estimated acquisition costs would be based on individual carrier estimates of the costs that physicians, or other providers as appropriate, actually pay for the drugs. Carriers could survey a sample of the physicians who furnish the drugs to obtain cost information. As an alternative, carriers could request that physicians periodically provide cost information when they submit claims for payment for the drugs. For certain types of drugs, such as chemotherapy drugs, there may be significant indirect costs such as inventory costs, waste, and spoilage. Carriers may consider these costs, if documented, as part of the acquisition cost of a drug.

For high volume or high cost drugs as determined on a national basis, we may designate certain carriers, which represent different geographic areas of the country, to survey physicians in their area to determine the average cost of the drugs. We will distribute the results of these surveys to all carriers. Carriers will be free to evaluate the results of the surveys and use this information in conjunction with any information they have obtained locally to determine the payment for the drugs in their service areas. The revised payment policy for drugs appears in §§ 405.517 and 415.36 of the final regulations.

[Antigens as Drugs]

Comment: Commenters objected to our considering antigens to be drugs or biologicals, and therefore asked that they be excluded from the fee schedule and paid on a reasonable charge basis. They stated that antigens are covered under section 1861(s)(2)(G) of the Act. Also, they noted that that section of the Act is not identified in the definition of "physicians' services" for fee schedule purposes set forth in section 1848(j)(3) of the Act.

Response: After considering the comment, we agree with the commenters. Thus, we are excluding antigens prepared by one physician for administration by another from the physician fee schedule (CPT codes 95135 through 95170). Carriers will continue to pay for these antigens under the current payment methodology.

[Payment for Injection Administration]

Comment: Commenters objected to the proposed policy for drugs and the related bundling of payment for administration of injections into other medical services furnished at the same encounter as presenting a "double hit". They stated that not only would the physician be paid less than his/her cost for the drug, but also, there would be no payment for the additional service of the injection furnished to the patient. They stated that this approach is inconsistent with payment based on resource costs.

Response: As we indicated in our discussion of payment for drugs, we have revised our proposed payment policy for drugs. With respect to payment for injections, we have decided to pay separately for cancer chemotherapy injections, including intra-muscular, intravenous, intra-arterial, and subcutaneous injections, in addition to the visit furnished on the same day. Commenters made a convincing case that these cancer chemotherapy injections are more complex than other injections incident to a physician's service. Therefore, we will pay for all injection procedures in the CPT range of 96400 through 96549 separately in addition to any visit service furnished. For further information on how to bill for the visit, see the discussion on modifiers that appears in this section of the preamble.

We were not convinced by commenters, however, that other intra-muscular, intravenous, intra-arterial, and subcutaneous injections are sufficiently complex that separate payment should be made for them. Therefore, payment for CPT codes 90782 through 90784 will be included in payment for visits or other procedures that are furnished on the same day.

[Payment for ESRD Drugs]

Comment: Several commenters objected to applying the proposed 85 percent of AWP allowance for drugs to ESRD facilities. They stated that their costs for drugs used to treat ESRD patients are greater than this due to several factors.

Response: We are accepting the commenters' suggestions not to apply the proposed 15 percent reduction of the currently allowed AWP for drugs and to consider their invoice costs in determining allowances for ESRD drugs. Therefore, the new payment allowance will be the lower of the facility's estimated acquisition cost of the drug (for example, as determined by the invoice) or the national AWP of the drug. The program's payment will be subject to the usual Medicare Part B

deductible and coinsurance requirements.

B. Formula for Computing Payment Amounts

Section 1848(a) of the Act specifies that payment for Medicare physicians' services must be based on the lesser of the actual charge or the payment amount computed under the fee schedule. Although the law refers to the fee schedule values as "payment amounts", in fact under the statutory formula the amount paid directly to a physician by Medicare will be 80 percent of the actual charge or 80 percent of the fee schedule payment amount, whichever is less. The beneficiary is required to pay the remaining 20 percent. Throughout this final rule, we have used the terms "fee schedule payment amount," "payment amount," "payment," and "allowed charge" as used in the statute to include the amounts for which both the beneficiary and Medicare are responsible.

Under the formula set forth in section 1848(b)(1) of the Act, payment amounts for particular services under the physician fee schedule will be computed as the product of three factors: (1) A relative value for the service, (2) the GAF for the fee schedule area, and (3) a nationally uniform dollar CF. (Although we generally describe a single nationally uniform CF, different CFs for surgical services and other services may be established as part of the MVPS and annual update process. A discussion of the update process appears in the section on the CF.) This general formula can be expressed as:

$$\text{Payments} = \text{RVU}_t \times \text{GAF}_{ta} \times \text{CF}$$

where

RVU_t = Total relative value units for the service

GAF_t = Total geographic adjustment factor for the fee schedule area

CF = Uniform national CF

_s = Service

_a = Fee schedule area

Section 1848(e)(2) of the Act requires the total GAF for a fee schedule area to be the sum of three components, relating to the three components of the total RVU for a service. The three components are:

- (1) Physician work;
- (2) Practice expenses or overhead, such as rent, staff salaries, equipment, and supplies, exclusive of professional malpractice liability insurance costs; and
- (3) Professional liability insurance or malpractice costs.

Section 1848(c)(1) of the Act defines the components of the RVU for a

physician service. The physician work RVU must reflect the physician resources required to furnish the service, including time and intensity of effort. Under the formula specified at section 1848(c)(2)(C), the practice expense and malpractice RVUs are based on historical data for practice expense as a fraction of total physician revenue, weighted by specialty, applied to estimated 1991 average allowed charges under the customary, prevailing, and reasonable charge methodology.

Separate GPCIs have been developed for the three components of the fee schedule. Under section 1848(e) of the Act, the GAF is equal to a weighted average of these three GPCIs. Thus, when the GAF is expressed as the sum of its three components, the formula becomes:

$$\text{Payments} = \text{RVU}_s \times [(\text{GPCIw}_s \times w_s\%) + (\text{GPCIpe}_s \times pe_s\%) + (\text{GPCI}_m \times m_s\%)] \times \text{CF}$$

where

GPCIw_s = GPCI value reflecting one-fourth of geographic variation in the value of physician work applicable in the fee schedule area

GPCIpe_s = GPCI value for practice expense applicable in the fee schedule area

GPCI_m = GPCI value for malpractice expense applicable in the fee schedule area

$w_s\%$ = Work percentage for service,
 $pe_s\%$ = Practice expense percentage for service,

$m_s\%$ = Malpractice percentage for service,

The work, practice expense, and malpractice percentages are the fraction of the total RVUs for a service represented by the work, practice expense, and malpractice RVUs, respectively; they sum to 100 percent.

In effect, this statutory formula accomplishes separate adjustment of each of the three components of the total RVUs for each service by the value for the fee schedule area of a GPCI specific to that component. (The statute specifies, however, that only one-fourth of the geographic variation in physician work resource costs is to be taken into account in the formula.) The three GPCI-adjusted RVU values are summed to produce a total RVU value, which is converted into a dollar payment amount specific to that service and that fee schedule area by application of a uniform, national CF. Thus, for ease of computation and understanding, we have transformed the original formula stated above into an algebraic equivalent as follows:

$$\text{Payments} = [(\text{RVUw}_s \times \text{GPCIw}_s) + (\text{RVUpe}_s \times \text{GPCIpe}_s) + (\text{RVUm}_s \times \text{GPCI}_m)] \times \text{CF}$$

where

RVUw_s = Physician work relative value units for the service

RVUpe_s = Practice expense relative value units for the service

RVUm_s = Malpractice relative value units for the service

Sources of each of these elements of the payment formula are explained in more detail in the sections below. Included within the discussion of the CF computation below is an explanation of payment rules during the transition years 1992 through 1995.

[Payment of Board-Certified Physicians]

Comment: Some commenters believe board-certified physicians should be paid more than general practitioners and other nonboard-certified physicians.

Response: Physicians become board-certified to attain specialty status. Section 1848(c)(6) of the Act prohibits specialty payment differentials. By law, the RVUs for a service are the same for all physician specialties.

C. Sources of Relative Value Units (RVUs)

1. Physician Work RVUs

Section 1848(c)(2)(A) of the Act, as added by Public Law 101-239, authorizes the Secretary to establish the RVUs for the physician fee schedule after considering recommendations of the PPRC and consulting with organizations representing physicians. The majority of physician work RVUs that form the basis of the physician fee schedule (see addendum B of the proposed rule) were developed by a research team at Harvard University under a cooperative agreement with us. (All of the work RVUs in the proposed rule were based on Harvard data; some final rule work RVUs came from other sources, as explained in subsequent sections of this preamble.)

In Phase I of the Harvard study, 372 unique services representing about 200 unique CPT codes were investigated through surveys. By extrapolation, the Harvard team developed physician work RVUs for about 1,400 services representing about 1,200 unique CPT codes. Under Phase II, additional specialties were surveyed. With the results of Phase II, we have work values for 460 unique CPT codes from survey data and with extrapolated data, we have values for over 4,000 codes representing a large percent of Medicare dollars. Under Phase III, a small group process has been used to develop RVUs for many remaining services for which we had no work RVUs, to generate values for new visit codes, and to create RVUs for most of the previously extrapolated services.

In this first section, we provide our responses to comments on procedural issues of how we presented information in the proposed rule.

a. Procedural issues.

[Opportunity for Submitting Comments]

Comment: Commenters stated that the proposed rule did not include significant information that will be the basis for this final rule, thereby denying any meaningful opportunity for comment. Commenters cite the fact that there was not an RVU for each service and our acknowledgement that some RVUs would change as a result of information furnished by Harvard after the publication of the proposed rule as demonstration that we did not provide an opportunity for public comment on the RVUs. Commenters stated that our providing certain information to specialty societies on Phase III results after the publication of the proposed rule was insufficient to correct this deficiency. Others stated that this process will encourage us to establish RVUs that are inappropriately low in order to achieve budget savings and urged us to make future changes retroactive. Other commenters stated that our process violates the requirements of the APA (5 U.S.C. 553 (b) and (c)).

Response: As we stated in the proposed rule, we are bound by the statutory date of January 1, 1992 for implementing the fee schedule. We published RVUs for all services for which we had Harvard RVUs at the time the proposed rule was published. The services for which the proposed rule contained RVUs comprised approximately 86 percent of the Medicare payment that will be made under the fee schedule, and the services that were not included were generally low frequency services. Because there was by necessity a lack of opportunity to comment on all the proposed values and many values changed after publication of the proposed rule, we have decided to consider the values published in this final rule to be initial values on which we will accept public comment.

We are, therefore, providing a 120-day period for comment on all the RVUs included in this final rule. Any changes in the values made as a result of comments received will be prospective only and will be announced in a notice to be published in the Fall of 1992 to be effective January 1, 1993.

We strongly disagree with the comment that an incentive exists to establish inappropriately low initial values as a way to achieve savings. The

entire payment system is required to be implemented in a budget-neutral manner, and future RVU adjustments must be made in a way that does not cause total payments to increase or decrease by more than \$20 million. Therefore, underestimates of RVUs will not result in savings.

Finally, we believe we have fully complied with the APA. We provided the opportunity for public comment on all RVUs established when the proposed rule was published on June 5, 1991. Given the statutorily effective date of January 1, 1992, there was no opportunity to request public comment for values established after that date.

[Time and Intensity of Effort]

Comment: Commenters stated that we failed to develop a resource-based fee schedule that expresses both time and intensity of effort as required by section 1848(c)(1) of the law. Commenters stated that while the Harvard study measured time, it failed to take valid measures of intensity of effort and therefore did not meet the statutory test.

Response: As indicated in the Harvard study, "intensity of work" was defined as work per unit time, and as such the Harvard values reflect the intensity of physician work as well as the influence of time on the value. Harvard's work values reflect total work, which includes both time and intensity.

[Estimates of Pre- and Post-Service Work]

Comment: Commenters objected to the absence of the estimates of pre- and post-service work for the work RVUs in the proposed rule; they argue that these estimates underlie the work RVUs and that their absence seriously impedes the public's right to comment on these questions.

Response: We do not believe the absence of pre- and post-estimates of physician work seriously inhibited comment on the total work RVUs in the proposed rule. We received comments on the RVUs for approximately 1,000 services. Many of these comments indicated that there were rank order anomalies in the RVUs. We proposed to pay physicians based on the total RVU for a service, and it is the total RVU that determines the placement of a service on the fee schedule. The absence of pre- and post-work estimates does not inhibit a commenter from commenting that the placement of the total work of a service is incorrect or from identifying the extent to which the error in value exists. In addition, we did share pre- and post-service work estimates with all

specialty societies in a separate mailing sent out in early July of 1991.

b. *Visit code comments and responses.* Section 1848(c)(5) of the Act requires the Secretary to establish a uniform procedure coding system for the coding of all physicians' services, including an appropriate coding structure for visits and consultations.

In 1983, we announced the requirement that physicians and carriers use the HCPCS to code and bill for physicians' services. The HCPCS has three levels:

Level 1—CPT.

Level 2—Alpha-numeric HCPCS codes.

Level 3—Carrier-unique local codes.

The CPT is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians. The HCPCS includes CPT descriptive terms and numerical identifying codes and modifiers for reporting medical services and procedures and other materials contained in the CPT that is copyrighted by the AMA. We have an agreement with the AMA to use the CPT for coding of physician services.

The CPT currently distinguishes among visit services for six sites of service: office/outpatient services, home, inpatient hospital, emergency department, NF, and domiciliary care facilities. The CPT also differentiates between new and established patients for several sites; in some other sites, a distinction is made between initial and subsequent visits. In addition, the CPT contains specialized visit codes for several categories of services, including psychiatric, dialysis, ophthalmologic, and critical care visits. Visits are defined separately from consultations.

There currently is wide variation in the coding of physician visits. Much of the variation in coding is due to the subjective nature of the current CPT visit definitions.

In the proposed rule, we stated that our goal for the development of new visit and consultation codes is that the new codes meet two criteria:

- They should be used reliably and consistently by all physicians and carriers; that is, the same service should be coded the same way by different physicians.
- They should be defined in a way that enables us to properly crosswalk the new codes to the relative values for the Harvard vignettes so valid RVUs for work are assigned to the new codes.

Since the model fee schedule was published in the *Federal Register* on September 4, 1990 (55 FR 16378), there have been several phases of the

Harvard study that have provided information for use in the creation of new visit codes. Phase II of the Harvard study focused much of its effort on a more intensive study of visits and consultations than Phase I. Between Phases I and II, Harvard studied 31 specialties for 414 visit vignettes, and provided work and time values for all vignettes surveyed and relative values for each CPT visit code by physician specialty. The latest Harvard results, including some of the Phase III results, were used in the proposed rule. We did not use, however, any results that were products of extrapolations as opposed to physician surveys or the Phase III small group process. After publication of the proposed rule, we received more Phase III results, which were sent to numerous specialty societies in July of 1991. Earlier that month, these organizations were also sent information on the composition (pre, post, and intra) of the Harvard relative work estimates for each procedure.

Review of the work values for each CPT visit code by physician specialty indicates that the range of work values for the current CPT codes varies significantly.

CPT Editorial Panel developed new visit codes for office visits, hospital visits, and consultations at its November 2 through November 4, 1990 meeting. The CPT Editorial Panel carefully considered the recommendations of the PPRC Consensus Panel and the findings from Phase II of the Harvard study in its development of new visit codes. In addition, in developing the new visit codes, the CPT Editorial Panel considered the issues we raised in our discussion of visit codes in the model fee schedule notice (55 FR 36178; September 4, 1990, Part IV). We published the proposed CPT codes for office/outpatient visits for new and established patients, initial and subsequent hospital visits, and initial and subsequent consultations in addendum E to the proposed rule (56 FR 25974).

We explained in the proposed rule that we had not at that time come to a decision regarding the coding of physician visits. However, we stated that, based on our review of research performed by the Harvard team, we believe that characteristics of a visit such as duration of the service, condition of the patient, new versus established patient for office visits, and initial versus subsequent encounter for hospital visits are related to the physician work in a visit and may be appropriate elements of a coding system for visits. We expressed our intention to

consider carefully comments on the proposed CPT visit codes and to examine the results from the pilot test of those proposed codes before developing our uniform visit coding policy as required by law.

In January of 1991, we initiated a pilot test of the proposed new visit codes jointly with the AMA. The pilot test consisted of two parts: A reliability test and a field test.

The reliability test was intended to answer the question: "Will different physicians bill the same services using the same codes?" We asked a total of 155 physicians to code detailed written descriptions of visits and consultations. Half of the physicians used a proposed CPT draft that included typical time in the code definitions and half used a draft that was identical except for the absence of typical time from the definitions.

A field test of the new codes was conducted as a supplement to the reliability study in order to determine how well the new codes would work for coding actual patient visits. It was also intended to help determine whether the variation in coding between carriers would likely be reduced by the new coding system. In the field study, 173 physicians coded visits in their practices using both the current and proposed CPT definitions. As with the reliability test, half of the physicians used a proposed CPT draft that included typical time in the code definitions and half used a draft that was identical except for the absence of typical time from the definitions.

- The reliability test showed that: Including time did not substantially affect the reliability of the coding. That is, physicians who used the definitions with time did not code more reliably than physicians who did not have time in the codes.

- The actual time taken to furnish a service does not dominate the coding practice. Actual time explains about 23 percent of the variation in the assigned code; clinical content explains about 77 percent of the variation in the assigned code. This effect is independent of whether time is included in the code definitions. Thus, when choosing the appropriate code, physicians placed much greater emphasis on the content of the service furnished rather than the time associated with the service.

- The "typical times" in the draft corresponded closely to the independent time estimates acquired from physicians.

The results of the field study were generally inconclusive because of low physician response rates. The field study did, however, yield some

information that was used to establish the crosswalk from old visit codes to new visit codes. Further, both studies indicated that physicians can easily and reliably use the new codes without substantial difficulty. This conclusion is supported by focus group discussions conducted as part of the laboratory study and questionnaire responses by physicians using these codes in their practices as part of the field study.

In addition to the office, hospital, and consultation codes described above, the CPT Editorial Panel has developed new draft descriptors for home visits, nursing facility visits, domiciliary care facility visits, emergency department visits and critical care visits. The definitions of these visit codes are contained in Addenda E of this final rule.

[Selection of Coding Systems for Visits]

Comment: Commenters expressed a wide divergence of opinions on the system to be used for coding visits. Some commenters supported the proposed CPT codes without reservation, because they believe these codes offer a significant improvement over the current coding. Other commenters object to the implementation of the proposed CPT codes and asked that we implement and use the visit coding system proposed by the PPRC in its 1991 Annual Report. They stated that the proposed PPRC codes are easier to understand and to use than the proposed CPT codes. Other commenters opposed any revision of visit codes in 1992. Some of these commenters opposed implementation of the new CPT codes until further testing has occurred because they are not confident of the impact of simultaneous implementation of the fee schedule and coding changes for visits; they asked that we implement the fee schedule using current CPT codes and change to the new CPT codes after fee schedule payment has begun. Other commenters who opposed any revision to the codes were opposed to both the CPT and the PPRC proposed visit codes because of the inclusion of time as a factor in determining the level of the visit. Some commenters opposed the CPT visit codes because physicians who were not MDs were not involved in the development of codes for visits, which are a large part of a nonphysician's practice.

Response: We have based the RVUs for visits on the definitions of "visits" contained in the new CPT visit codes for 1992. We made this decision because the CPT visit codes were created based upon the same Harvard research that furnished RVUs for the codes and we are therefore confident that the RVUs

accurately reflect the physician work for the code. Moreover, the proposed visit code definitions were well received by physicians during a joint AMA/HCFA pilot test. We are confident that the new visit definitions meet the intent of Congress as expressed in section 1848(c)(5) of the Act, which requires us to establish uniform coding for visits beginning January 1, 1992.

We do not support use of the PPRC proposed visit codes, because we believe the PPRC descriptors do not adequately encompass the variation in the complexity of the evaluation and management services that are furnished in visits in divergent settings and circumstances. The PPRC's proposed visit codes have fewer definitions than the CPT codes, but we do not agree that fewer definitions will necessarily result in more accurate coding of visits. In fact, the CPT Editorial Panel began its work on visit coding with an approach similar to that of the PPRC and adopted many of the recommendations that evolved from the PPRC's consensus process. These recommendations included using 5 levels of service for office visits, and using site of service to classify visits. It soon became apparent, however, to CPT Panel members that PPRC's identical definitions for levels of care in these divergent settings and circumstances such as inpatient hospital admissions and follow-up office visits would not result in reliable coding. We also disagree with PPRC's view that the number of different CPT visit codes for 1992 makes the system too complex for physicians to use since physicians have, throughout the history of medical coding, demonstrated the capacity to use hundreds of different codes to describe their services.

We did not retain the current CPT codes for visits, because we cannot provide RVUs for them that would be reliable and fair across geographic areas and specialties. Phase II of the Harvard study revealed a tremendous range and variation in RVUs for vignettes within the same CPT visit code under the current system. The specialty of the physician made a great difference in the amount of work in a single CPT visit code. For example, physician work RVUs for code 90020 ranged from 108 RVUs for dermatology to 307 RVUs for infectious diseases (Harvard Phase I scale raw values dated November 1990). Because section 1848(c)(6) of the Act prohibits us from assigning different RVUs or CFs based upon physician specialty, applying the Harvard research on visit codes using the current CPT visit codes would significantly underpay physicians in some specialties and

overpay others. We believe the requirement in section 1848(c)(5) of the Act that we must establish uniform coding for visits beginning January 1, 1992 was intended to avoid this inequity. Therefore, we do not support the implementation of the fee schedule based on visit codes that would force us to use RVUs that do not appropriately reflect the physician work in visits.

[RVUs for Visits]

Comment: Commenters stated that the relationship between work and time that was used to generate work values for visit codes was incorrect since average values of work and time for vignettes were used in establishing the relationship rather than the individual responses of physicians. As a result they claim that the 'simpler' visit codes should be valued lower and the more complex codes should be valued higher.

Response: We believe the methodology that was used to generate work estimates for the visit codes is appropriate and consistent with the methodology that was used to generate work values for other codes. We believe it is conceptually appropriate to estimate the relationship between mean work and mean time since the coding system is based on the typical relationship between work and time. Furthermore, since the means of work and time were used as the basis of analysis for other services, they were also used for the visit code analysis. Finally, we believe the regression that was used by Harvard to generate work values for visits yielded valid results.

[Inclusion of Time in Visit Codes]

Comment: Some commenters opposed the inclusion of time as a factor in the level of the visit to be coded. They believe the inclusion of time will penalize the specialist who makes complex management decisions more quickly than the nonspecialist or less competent physician. Some commenters are concerned that the inclusion of time will result in carriers basing the payment for the service on the duration of the encounter rather than the content of the visit. Other commenters supported the inclusion of time in the definition of levels of care, but only if time is secondary to content in selecting the appropriate level of care. Commenters stated that the content of the service, rather than the duration of the visit, should be the primary factor in the level of visits coded. Commenters are concerned that there will be a lack of congruence between time and content in visit coding, which will result in conflict between physicians and carriers over the appropriate visit coding.

Response: The average or typical time for producing a service and the relationship between work and time served as the basis for assigning an RVU to each visit code. For visit codes, there is not the same degree of precision in distinguishing one code from another as is generally true of procedural services. We believe the new content descriptors for distinguishing one level of a visit code from another are a vast improvement over the current definitions and will yield more uniform coding. We believe the inclusion of time as a secondary factor in determining the level of visit to bill will help physicians to decide the level of service in borderline cases. The typical times shown in the visit code definitions are not, and have never been intended to be, the defining factor in how to code a visit. We will undertake training and educational activities with Medicare carriers to ensure that this is fully understood. The physician, however, continues to be responsible for having documentation available, if requested, to justify the level of visit billed.

[Face to Face vs. Total Time in Visit Definitions]

Comment: Commenters objected to the inclusion of face-to-face time in code definitions. Commenters believe total time (pre- and post-time in addition to duration of face-to-face time) should be used in the definition of visits because they believe much of the work performed as part of the visit is pre- and post-work.

Response: Although the typical time for visits does not include pre- and post-time, the work performed before and after the face-to-face encounter has been included in calculating the total work of typical services for the code.

Therefore, we believe the face-to-face time associated with the services is a valid proxy for the total work done before, during, and after the face-to-face encounter. We believe physicians can estimate face-to-face time more reliably.

[Face-to-Face Times in the Visit Codes]

Comment: Some commenters stated that the face-to-face times shown in the visit codes are too high, and they are concerned that if time is used by carriers in setting appropriate codes to be used, widespread downcoding will occur. They noted that specialists take less time to make more complex decisions and should not be penalized by making them in less time than may be typical.

Response: We have not revised the typical times included, as secondary factors, in the visit definitions because the pilot test of the visit codes in which

we participated with the AMA in January 1991 indicated that the times were reasonable. Moreover, the RVUs assigned to the visits were assigned roughly based upon the typical times shown. If the typical times are reduced for the visits, the RVUs for the visits will be reduced.

[Modifier for Cognitive, Physical, ADL Impairments, Advanced Age and Extra Counseling]

Comment: Some commenters asked that we establish and recognize a modifier that would increase the RVUs for a visit if the patient has cognitive or physical disabilities or needs assistance with activities of daily living, because they believe these impairments increase the amount of physician work in the visit. Some commenters requested that we establish and recognize a modifier that would increase the RVUs for visits due to advanced age because they believe advanced age increases the amount of work in the visit. Other commenters requested that we establish and recognize a modifier that would increase the RVUs for visits for patients who required more counseling than patients in that level of service would typically require.

Response: We have not established or recognized these modifiers. We are not convinced by the comments that the presence of cognitive or physical impairments or ADL impairments, or advanced age creates substantially more work for the physician in performing the services contained in the visit definition; nor are we aware of any data that suggests, to the extent there is any extra work associated with patients with cognitive or physical impairments, that these patients do not reasonably average out for physicians. Moreover, we would be very concerned about introducing subjective judgments such as the existence of a cognitive impairment in determining payment for visits. Phase II of the Harvard study, which was directed to visit services and which addressed the issue of the effect of age on work values was inconclusive with regard to whether and if so, how age impacted work values. Therefore, the CPT has not created such a modifier, and at this time, we are not convinced that additional payment would be appropriate if there were such a modifier.

The CPT Editorial Panel has added a new modifier to the 1992 CPT for the reporting of prolonged evaluation and management services. Modifier 21 is used to report services that are prolonged or otherwise greater than that usually required for the highest level of

evaluation and management services within a given category. This modifier will be used for informational purposes only. It will not be used for payment purposes. We plan to monitor and review usage of the modifier to get a better understanding of the nature and value of codes if the modifier applies.

[Counseling and/or Coordination of Care Visits Without History/Examination]

Comment: Commenters stated that it is not clear how physicians should bill visits that are only for counseling and/or coordination of care and no history or physical examination is performed. Commenters stated that there are many visits, particularly when patients are newly diagnosed with serious illnesses, in which education, counseling, scheduling and/or helping the patient make treatment/care decisions are the only services furnished. Commenters want clarification of what visit codes they should use to bill for these visits.

Response: Visits in which more than 50 percent of the service is counseling or coordination of care, or both, should be coded based upon the duration of the visit. The physician must document the medical records to reflect that duration.

[Visit Crosswalk]

Comment: Commenters objected to the proposed crosswalk for visits, which is our estimate of the frequency of new visit codes based on the frequency of current codes. Some commenters objected to the absence from the proposed rule of all the data and documentation on which we based the crosswalk and stated that absent this information, they could not do any analysis of the crosswalk. Some commenters supported use of the crosswalk performed by the PPRC. The PPRC suggested that if the visit codes were crosswalked based upon the distribution of typical times in their visit survey and data from the National Ambulatory Medical Care Survey performed by the Public Health Service, then a greater proportion of visits would fall into the lower RVU ranges and the CF would be higher than under our estimates. Commenters also stated that we should crosswalk old codes to new codes in a way that eliminates any carrier-specific variation. Commenters believe we have no basis on which to estimate that so many visits will be billed using the higher level codes. Commenters believe we should be able to revise the CF if our crosswalk is wrong.

Response: We have not changed the crosswalk for office visits, hospital visits, and office consultations from the

crosswalk proposed in the proposed rule because we continue to believe it is the best estimate of how physicians will bill under the new codes. In developing the crosswalk, we carefully considered four sources of information: (1) Analysis of the content descriptions in the current and new codes, (2) Data from the AMA and HCFA coding pilot, (3) Harvard survey data, and (4) Data from the National Ambulatory Medical Care Survey (NAMCS). With respect to data from NAMCS, we did not directly use data on duration of visits because time is intended to be a secondary factor in assigning codes. Also, NAMCS data reflects only average time associated with office visits and does not reflect any information on the content described in the new visit codes.

[Effect of New Visit Codes on CF]

Comment: Commenters objected to the reduction in the CF that results from changing to a new set of visit codes.

Response: We disagree that the change to a new set of visit codes results in a lower CF than would be present if the old visit codes were used. As we discussed in our response to the comments on the crosswalk from old visit codes to new visit codes, we based the estimates of the new visit frequencies upon careful examination of code descriptions.

[Definition of "New" Patient]

Comment: Commenters supported the definition of a "new" patient as a patient who has not been seen by an individual physician within 3 years. Some commenters were particularly concerned that in the case of clinic services or group practice services, the patient should be considered to be "new" whenever the individual physician has not seen the patient within 3 years, regardless of whether other physicians in the clinic, or group practice have seen the patient within the 3-year period. Commenters asked that we clarify how physicians should code visits when a patient is referred to another physician in the same specialty and within the same medical center, clinic, or practice. Commenters also asked that we clarify that a patient can be billed as a new patient when a "locum tenens" physician sees a patient on behalf of the patient's attending physician if the locum tenens physician has not seen the patient within the last 3 years.

Response: The 1992 CPT defines a new patient as one who has not received any professional services from the physician within the past 3 years. An "established patient" is defined as one who has received professional

services from the physician within the past 3 years. For Medicare payment purposes, we interpret the term "physician" in these definitions to include all physicians practicing in the same group and billing with the same billing number. Therefore, in the case of group practices if a patient has been seen by any physician in the group or clinic, within a 3-year period, the patient is considered "established". If a physician is on call for or covering for another physician, the patient's encounter will be classified as it would have been by the physician who is not available. Thus, a "locum tenens" physician who sees a patient on behalf of the patient's attending physician may not bill a new patient code unless the attending physician has not seen the patient for any problem within 3 years.

[Patient-Requested Consultations]

Comment: Commenters wanted us to clarify that when a patient requests a consultation and the physician furnishes the same consultative services that he/she should furnish if another physician were requesting the consultation, the physician may bill and be paid for a consultation rather than a new patient visit. They stated that the work is the same, whether the physician requests the consultation or whether the patient requests it and that in a resource-based payment system, the billing and payment should be the same for the service.

Response: The CPT description of "consultation" clearly states that a "consultation" requested by a patient or family members of the patient, and not requested by another physician, is not reported using the initial consultation code. We disagree with the statement that the work is the same since true consultations require a written report for the referring physician.

["Grace Period" for Using Old Visit Codes]

Comment: Commenters asked for a "grace" period within which physicians can bill using the old visit codes.

Response: Physicians will be required to bill using the new visit codes for all services furnished beginning January 1, 1992.

[Visit Coding in Teaching Hospitals]

Comment: Some commenters stated that teaching physicians in major medical centers should be paid the same as other physicians as long as the service is the same, but that they should not be paid for a level of service unless the service meets all of the requirements for the level being billed. Other

commenters stated that we should recognize that the typical visit in the academic hospital setting is a higher level of visit than in other settings and we should acknowledge that higher visit codes will be submitted by physicians in these settings. If we are unwilling to acknowledge that higher level visit codes are justified for physicians in academic settings, we should recognize the prolonged attendance code and permit payment for it if associated with the visit codes in academic settings. Other commenters were concerned that the time spent face-to-face with the patient by a teaching physician is a much lower fraction of total work than for the nonteaching physician and that an emphasis on time could be unfair to them. Commenters want the CPT panel to explore the issues involved in use of the general visit codes in academic practice. Other commenters stated that RVUs for visits are too low for physicians practicing in teaching hospitals because the patients are typically sicker and the use of RVUs for the typical patient would not result in fair compensation to the physician for those patients.

Response: We have neither furnished a modifier for payment for services in teaching hospitals nor have we increased the RVUs for services in these settings, because we have no research that demonstrates that the physician work in the teaching hospitals is greater than in other hospitals. As indicated elsewhere in this preamble, clinical content is the primary basis for coding, so teaching physicians will not be penalized because they have a different balance of face-to-face and pre- and post-time. We are not recognizing the prolonged attendance code because we believe this has application primarily to critical care services, and the critical care codes properly reflect the work involved in furnishing critical care services.

[High Level Visit Code Requirements for Multiple System Workup]

Comment: Commenters stated that the complex visit codes should not be restricted to multiple system problems because this would prevent physicians whose specialty is based only on one body system (for example, urologists and ophthalmologists) from using the highest visit codes when they furnish complex services within one body system.

Response: The CPT codes define comprehensive physical examination as being "a complete single system specialty examination or a complete multi-system examination." As such, if appropriate, complex services within

one body system can be coded at the highest level of visit code.

[HCFA Funding of AMA Training of Physicians on New Codes]

Comment: Commenters asked that we fund the AMA to perform nationwide training on new codes.

Response: Medicare carriers will conduct training and educational sessions on the new CPT codes and the State medical societies will be invited to participate. We have worked closely with the AMA to develop an educational program that we expect will reach nearly every physician before implementation of the fee schedule.

[Preventive Care Codes]

Comment: Some commenters were concerned about the age ranges contained in definitions for preventive medicine codes.

Response: Preventive medicine services are not included in the fee schedule since section 1862(a)(1)(A) of the Act restricts coverage to services related to the diagnosis or treatment of an illness or injury.

[Emergency Department Visits]

Comment: Commenters supported the establishment of 5 levels of service for emergency department visits with no distinction between new and established patients and without the inclusion of time as a factor in the definition of emergency department visits. Commenters objected to the methodology in Harvard Phase II that they believe resulted in undervaluation of emergency department services during the intra-specialty linkage.

Response: Since the proposed rule was published, the AMA has established new definitions for emergency department codes, and Harvard has reconstructed RVUs for the new visit codes that we believe resolve the problems that existed with previous Harvard values for these services.

[Number of Levels of Service for Initial Hospital Visits]

Comment: Some commenters stated that three levels of care for initial hospital care do not adequately provide for variation in clinical practice.

Response: We believe three levels of initial hospital visits are sufficient to properly pay for the work in these visits. The CPT Editorial Panel began the creation of new visit codes for all classes of services with no preconceived ideas about the number of classes of visits or the number of levels of services within a class, once a class was agreed upon. The Harvard data supports three levels of service for these visits, and we

believe that the variation that exists within initial hospital visits can be properly accounted for in three levels of service for this class of visits. Also, the current coding system has only three levels, and physicians have not previously requested that this number be increased.

[Variation of Work Within Levels of Service]

Comment: Commenters stated that the amount of work that may be associated with a problem of "moderate severity" may vary tremendously and that they have difficulty seeing how a single value can reflect the difference.

Response: The nature of the presenting problem is only one of the factors that determines the appropriate visit code, and it is not considered one of the key components. If the physician considers all of the other dimensions of the visit (for example, level of history and physical examination), the variation that might otherwise exist if the nature of the problem were the only factor considered diminishes.

[Inadequacy of Visit Codes for Some Specialties]

Comment: Commenters stated that some of the specialties whose practice is mostly visits furnish services that are not typical evaluation and management services described in the visit definitions and therefore, the visit definitions have little relevance to the care they furnish (for example, pain management physicians, endocrinologists, and critical care physicians). Commenters stated that physicians should not be required to use visit codes and be paid under RVUs that have little or no relevance to the services they furnish.

Response: We currently believe the code definitions can be used by the commenters. However, if specialties believe the definitions of visits do not describe the services they furnish and no other CPT code properly describes the service either, they should present their concerns to the CPT Editorial Panel for possible creation of a code that may more properly describe the service.

[Special Ophthalmology Visits as Primary Care]

Comment: Commenters want us to add the special ophthalmologic visit codes to the primary care list so that they will be treated like primary care services, rather than specialized services, for purposes of payment updates.

Response: The list of primary care codes was established by section 4044

of Public Law 100-203. There is no statutory basis to provide for future differential updates for primary care services.

[Psychotherapy Visit Codes]

Comment: Commenters stated that the single code for a 50-minute psychotherapy visit (CPT code 90844) is not sufficient to capture the range of work that is found in that service. Therefore, continued use of that code would not result in equitable payment for the services coded under it.

Response: The issue of whether there is a need for further refinement of this code requires further consideration. The work value for this code, however, has been increased by 23 percent from the proposed value. We encourage commenters to make their concerns known to the CPT Editorial Panel.

[Require Reporting of Modifier and License Number for PTs]

Comment: Commenters requested that we require in regulations that the services furnished "incident to a physician's service" must be furnished by qualified individuals. For this reason, they supported requiring use of a modifier if a service incident to a physician's service is furnished by an individual other than a physician. In the case of physical therapy, they asked that we require the license number of the PT who performed or supervised the service to be submitted on the claim form.

Response: As we explain further in our discussion of modifiers, we have decided not to use this modifier for nonphysician services at this time. Similarly, we are not requiring reporting of the license number of the PT who performed or supervised a service incident to a physician service because of the burden it would impose on the physician. We are confident that physicians will use only qualified personnel to furnish these services.

[Coding for Physical Therapy Services]

Comment: Commenters requested the addition of codes for physical therapy services to the CPT or to the alpha-numeric HCPCS. They commented that the CPT does not represent the range of covered services furnished by PTs, and they state that the existence of alpha-numeric and local codes substantiates their argument. Commenters stated that the bundling of payment for physical therapy services into the HCPCS alpha-numeric codes M0005 through M0008 might only be acceptable if all providers (including both PTs and physicians) were required to use the codes. They added, however that this approach

would not eliminate the problems created by the absence of adequate codes for physical therapy services.

Response: We remain unconvinced that more codes are needed to describe physical therapy services. However, we acknowledge that the presence of both CPT and alpha-numeric HCPCS codes to describe physical therapy services is inappropriate and that a simple set of codes is needed. For this final rule, however, we have not been able to resolve this issue. In the meantime, we have established RVUs for physical therapy services for both the alpha-numeric HCPCS codes (M0005, M0006, M0007, and M0008) and the CPT codes (97110 through 97799). We expect to establish a national policy regarding the billing for these services for the 1993 fee schedule. Also, we have deleted the codes for rehabilitation evaluations (formerly H5220, H5230, H5240, and H5299), and we have crosswalked them to the CPT consultation codes (99241 through 99245). In the long term, we also intend to resolve the issue of how therapy services should be coded.

[Lack of Involvement of PTs in Setting RVUs]

Comment: Commenters objected to the lack of participation of PTs in the Harvard study and stated that, therefore, the values for physical medicine codes do not accurately reflect the work in the services. They urged that, until RVUs can be determined based upon the work of PTs as well as physicians in providing the services, RVUs for PT services should be calculated based upon average allowed charges for these services.

Response: RVUs for these services (both CPT codes and alpha-numeric HCPCS codes) were established based upon the national average allowed charges for the services.

[Billing of Visits by PTs]

Comment: Commenters stated that PTs should be permitted to bill for visits if they furnish evaluation services in order to ensure that payment to PTs equates to payment for physician services.

Response: PTs and physicians may bill using the appropriate M codes, which include office visits and physical therapy modality services.

[NF Codes]

Comment: Commenters stated that the new visit codes for nursing facility care should incorporate the requirements of Public Law 100-203 for periodic comprehensive assessments at admission (immediately upon any change in the patient's condition and 1

year after the most recent assessment), the work in quality reviews, and review of physical and chemical restraints. Commenters stated that the codes should take into account the work in monitoring multiple medications, physical and chemical restraints, and the revision of medical orders for patients without a history or physical examination as part of the visit.

Response: The CPT Panel has modified the NF visit codes to accommodate the requirements of Public Law 100-203 with regard to patient assessment and follow-up care.

[Critical Care Codes]

Comment: Commenters stated that critical care should be paid based upon the current CPT codes (99171 through 99174, 99160, and 99162) and that the RVUs should be established based upon surveys of critical care physicians. Commenters opposed using a single daily payment and the elimination of follow-up critical care codes because they believe the current critical care codes permit physicians to accurately code critical care services. They oppose basing payment for critical care on RVUs for subsequent hospital visit codes.

Response: The CPT Editorial Panel has eliminated the subsequent follow-up visit codes for critical care (CPT codes 99171 through 99174) because of extreme variation in use and interpretation across specialties and localities. We did not oppose the deletion of these codes because the Harvard research team found that the work in these visits is comparable to the work in the general subsequent hospital visits. The Panel revised the notes regarding the codes for critical care visits to clarify if the codes should be used and to be more specific about coding multiple episodes of critical care in a day. The two codes for critical care have been renumbered: 99291 ("Critical care, including the diagnostic and therapeutic services and direction of care of the critically ill or multiply injured or comatose patient, requiring the prolonged presence of the physician; first hour") and 99292 ("each additional 30 minutes"). These codes may be billed regardless of whether the physician's encounter for critical care is initial or subsequent. The CPT definition for the service includes procedures that are performed during the critical care period and are attendant to critical care management. These services may not be billed separately in addition to the critical care codes. Procedures that are not attendant to critical care management may be separately billed and will be separately paid.

We believe the new CPT codes provide an appropriate means for physicians to bill critical care services, since they provide a means for the physician to report the total duration of critical care services on a given day.

[Critical Care RVUs]

Comment: Commenters objected to the RVUs established for critical care codes because they believe no physicians who specialize in critical care were involved in surveying the services and therefore the RVUs cannot be valid. Commenters believe the reason the follow-up critical care visits were given values like subsequent hospital visits is that physicians who perform the critical care services were not surveyed and therefore the difference in values was not recognized.

Response: We have retained the Harvard RVUs for critical care services, because we believe they are valid. We reject the argument that these RVUs should be considered invalid because physicians specializing in critical care were not specifically surveyed.

Our data indicate that critical care services are furnished by a great variety of specialties. Based upon this finding, and the law's prohibition against payment of specialty differentials for the same services, we believe there is no reason to question the Harvard RVUs because the physicians who were surveyed were not specialized in critical care.

[Telephone Calls]

Comment: Commenters stated that if we are going to stop paying for telephone calls, we should add RVUs for this work to the visit RVUs.

Response: Although CPT has codes for telephone calls, carriers must not make separate payment for telephone calls. Medicare's policy has always been and will continue to be that telephone calls are part of the physician work in the visit or service and that payment for the visit or service encompasses the payment for the telephone call. The work in the telephone calls is already included in the RVUs for the visit since it is part of the pre- and post-work of the service.

[Concurrent Care]

Comment: Commenters stated that carriers must be instructed not to deny visits performed by several different physicians on the same day for the same patient unless they have evidence that the care of one of the physicians was not necessary to the treatment of the patient.

Response: Carriers will have improved information on physician

specialties that should reduce the number of queries about the possibility of duplication of services.

c. Independent studies that conflict with Harvard results. Six groups commissioned independent studies of RVUs which they submitted with their comments. All of them collected additional information from that gathered by Harvard, and the methods they employed to gather and analyze this additional information were slightly different from those used by Harvard. Each study yielded different relative work estimates for most procedures and specialties they examined.

Generally, these studies obtained and considered data from particular specialties, regardless of whether physicians with other specialties also performed some of the procedures being studied. Several studies used a type of magnitude estimation in which the reference procedure for work components varied from service to service rather than the method used by Harvard in which a constant reference procedure was used for all procedures done by the specialty. Only one of the special studies appeared to emulate the Harvard method of linking results from various specialties onto a common scale.

Most of the special studies yielded time estimates for performing studied services that were quite similar to Harvard's results, but their resulting total work values often differed from Harvard's, sometimes by multiples. In some of these study results the intensity values for important services raise questions of "face validity", such as having intensity for visits being greater than intensity for major coronary surgery or intensity for pre- and post-surgical services that were multiples of the Harvard intensity results for intensive care.

Each of these studies differed in important methodological ways from the Harvard study, and the differences in results appeared to be related to differences in methods. In a number of cases (for example, the choice of reference procedure for magnitude estimation) experts told us that both the Harvard approach and the approaches taken by the special studies were considered acceptable but could be expected to lead to different results. Consequently, we were unable to determine that either the special studies or the Harvard results were necessarily correct. As a result, we did not use the RVUs suggested by the special studies directly to replace the RVUs on the fee schedule published here.

Instead, we asked a group of CMDs to review all services whose values from

Harvard were questioned in these studies (an explanation of this process is included later in this section). As is noted elsewhere, many Harvard RVUs were adjusted by this process for various reasons, and the adjusted values will be used in the physician fee schedule.

In addition to referring questioned values to the CMD group, we asked the Harvard team to review these studies as well as other comments on the proposed rule. In our responses, we include a summary of Harvard's views.

[Abt Study for Cardiovascular and Thoracic Surgeons]

Comment: Based upon the results of an independently funded study by Abt Associates Inc., several commenters questioned the relative work values for a large number of CPT codes that are performed by cardiovascular, vascular, and thoracic surgeons.

Response: We sent this independent study to Harvard for review. In analyzing the study and comparing it to their own study, Harvard found that the independent study had more compressed RVUs for intra-service work than did their study. In particular, the ratio of relative work between the higher codes (surgeries) and lower codes (visits) is 70 percent greater in the Harvard study than in the Abt study. The primary issue raised by the independent study pertained to differences in the measurement of pre- and post-service work. In general, pre- and post-service times are similar across the two studies, however, pre- and post-service work estimates are more compressed in the Harvard study. Harvard stated that the pre- and post-work estimates are expanded in the independent study because of the methodology, which produces estimates of pre- and post-work that are highly correlated with intra-service work, and that this has resulted in RVUs that lack face validity. They stated that this is especially true when comparing intensity values across components of procedures. The independent study sometimes showed that the pre- and post-service intensity was greater than the intra-service intensity.

In light of the study and the comments, we questioned some of the values. We used our review process with CMD groups to assess the face validity of RVUs assigned to vascular and thoracic surgical codes that were contested by the independent study. As a result of the reviews by CMDs, we made a number of changes in the RVUs for cardiovascular and thoracic surgery.

[Battelle Institute Study for Gastroenterology]

Comment: Based upon the results of an independently funded study by the Battelle Institute, several commenters questioned the relative work values for a large number of CPT codes that are performed by gastroenterologists.

Response: We asked Harvard to help us review the methodology and the results of this study as well. In analyzing the study and comparing it to their own study, Harvard found that the independent study had more compressed RVUs for intra-service work than did their study. After linking the independent study to the Harvard scale on the basis of common procedures, they found that the intra-service work values for visits and consultations are higher in the independent study, while the opposite is true for procedures. The primary issue raised by the independent study pertained to differences in the measurement of pre- and post-service work. Also, Harvard questioned the face validity of the study results because they sometimes show that pre- and post-service intensity is greater than intra-service work intensity of the most difficult visits and consults.

In view of the issues raised by the independent study, and because of the face validity issues that were raised by studies with different methodologies, we used our review process with CMD groups to assess the face validity of codes that were contested by the independent study. We made a number of changes in the RVUs for services of gastroenterologists as a result of this review.

[Health Policy Alternatives Study for Transplant Surgeons]

Comment: Based upon the results of an independent study submitted by Health Policy Alternatives Incorporated, several commenters questioned the relative work values for many of the CPT codes that are performed by transplant surgeons. In particular, questions were raised by some commenters as to the ability of some of the surveyed physicians to rate the work of transplants because they do not regularly perform the service (that is, their "fitness to rate").

Response: As with the other studies, we asked that Harvard review the methodology of this study and the results. In analyzing the study and comparing it to their own study, Harvard concluded that the results of the independent study lacked face validity. For example, the independent study showed that the procedure with the highest intensity was a follow-up

office visit. Harvard also noted that the results of the more "experienced" surgeons in the independent study are not significantly different from the results of the "inexperienced" surgeons. Harvard did not perform a special investigation of transplant surgeons so transplant services were studied within the context of larger specialties. Harvard agreed that their treatment of transplantation did not produce as accurate a scale as was produced for other specialties. In particular, they are not confident that they have clearly defined or measured work for immuno-suppressive therapy.

In view of the issues raised by the independent study, we used our review process with CMD groups to assess the face validity of codes that were contested by the independent study. Based on this review we decided not to establish a national work value for heart and liver transplantation service. Rather, carriers will determine payments until we have better data. For kidney transplants, however, as discussed later, the value for this service was increased.

[Lewin/ICF Study for Cancer Research Hospitals]

Comment: Commenters asked that we exclude physician services furnished in PPS-exempt cancer hospitals from the fee schedule and continue to pay them under the reasonable charge methodology. Commenters believe physician services in these hospitals are atypical because patients are unusually complex and that RVUs for services (particularly the surgical services) are understated. They furnished an independent study that they believe demonstrates their contention.

Response: We have not excluded physicians' services that are furnished in PPS-exempt cancer hospitals from the fee schedule, because we have concerns about the study presented and we have no other information to sustain the claim that physicians' services in these hospitals have higher work values or higher intensity of work compared to other services that would receive the same codes.

We asked Harvard to review the methodology and values that were proposed in the independent study. In reviewing the study and linking the independent study with the Harvard scale on the basis of medians (as opposed to linking on the basis of means, as was done in the independent study), Harvard concluded that: (1) the intra-service work estimates in the independent study were higher than Harvard's for the more complex services, although the differences in

time estimates were not as great; and (2) pre- and post-service intensity values are often much greater in the independent study, and often are equal to intra-service intensity and sometimes are greater than intra-service intensity. These results suggested to Harvard a lack of face validity.

It is also our judgment that the commenters have not demonstrated that the services in their hospitals differ significantly from the services furnished in other major medical centers not exempt from PPS, and their exclusion from the fee schedule would therefore likely create inequities among physicians who perform the same services. Unlike PPS, which has a single payment amount for a given diagnosis and for which exemption for these cancer hospitals can be rationalized on the grounds that they provide a much different volume and mix of services, the physician payment system is a fee for service method of payment with some opportunity to reflect the level and frequency of service furnished. Thus, to the extent physicians in these hospitals furnish more consultations, more concurrent care by other specialties, higher level visit services, etc., all of these services can be reflected in physician billing.

Lastly, we do not believe a valid reasonable charge payment system could be sustained if the only charges in the charge profiles are from a single facility in a locality. Nevertheless, we will monitor services in cancer hospitals to determine whether adjusters might be appropriate in the future.

[Lewin/ICF Study for Interventional Radiology]

Comment: Some commenters stated that the cardiovascular and interventional radiology should be recognized as a separate specialty and that these services are not adequately described in the CPT. They cited an independently funded study report by Lewin/ICF, which included relative work estimates based on 4 small group surveys using a set of created codes and descriptions for vascular, nonvascular, neuroradiological, and cardiac services.

Response: We have not established a specialty code for this group of physicians, but we may in the future. The comments about the CPT should be raised by the commenters to the CPT Editorial Panel at the AMA. There was inadequate information furnished about these services and their volumes for us to create a set of HCPCS alpha codes for these services.

In addition, we sent the Lewin/ICF report to Harvard for review. Harvard

stated it believes the method used to estimate pre- and post-service is questionable because it shifts the standard used to obtain these estimates. That is, the magnitude of work for pre- and post-services is not estimated in comparison with the standard used for all procedures. Harvard believes this method when used in other studies yielded some results that lacked face validity. Harvard also criticized the method used in this study to link its resulting values to the RVs.

Because interventional radiology services are generally new, we also met with representatives of several of the specialties who furnish these services. The disparity in results for procedures valued by each group were discussed, and their recommendations were reviewed by the CMDs. The results of this review is discussed in a later section of this preamble.

[Abt Study for Pathologists]

Comment: An independently funded study by Abt Associates Inc. and related comments argue that one pair of vignettes linking pathology to gastroenterology should not have been given a weight of zero by Harvard because it was not an outlier. They claim that dropping the link reduced the work RVUs for pathology services by 20 percent.

Response: We invited Harvard's comments on this study. Harvard conducted two analyses to validate the Phase II pathology linkages and the position of Phase II pathology on the common scale. In Phase II of its study, Harvard conducted a national survey of physicians who were board-certified in both pathology and internal medicine and had the physicians rate the work of pathology and internal medicine services relative to the same standard. To validate the relationship of the pathology services on the common scale, Harvard compared the relationship between the work of pathology and internal medicine on this double boarded scale with the work on the common scale. Specifically, Harvard computed the ratio of double boarded work to common scale work. Harvard found that the relationships between the two scales are consistent with each other. Furthermore, the mean ratios between pathology and internal medicine were not statistically different. Finally, Harvard also found that the double-boarded physicians rated the two link procedures quite differently. These findings are consistent with Harvard's earlier conclusion that the link in question is an outlier. Based upon another analysis that used a panel of salaried physicians to identify links and

based upon the common scale values for these procedures, Harvard argued that the location of pathology on the common scale may, in fact, be too high. Nevertheless, because of the issues raised in this comment, we subjected pathology codes to our face validity process with CMD groups. A number of values for pathology services were changed in that process.

[Replacement of RVUs]

Comment: Some commenters supported the methodology of the Harvard study and objected to the use of any other studies to set RVUs for physician services.

Response: We believe all comments questioning relative values presented in the Harvard study, including those contained in other studies, deserve full consideration.

[Criticism of Linkages Between RVUs for Different Specialties]

Comment: Some commenters objected to the links used by Harvard to link specialties onto a common RVU scale. Some made specific objections to the equivalency of services between specialties. Other commenters supported the links used by Harvard and objected to the potential elimination, revision, or any other changes that might be made to the linkage of specialties to a common scale.

Response: Linkage across specialties was performed by identifying vignettes that were surveyed in two specialties that were the same or equivalent in terms of work (or occasionally time or intensity). The identification of links was made on the basis of face-to-face discussion with physicians from the specialties involved in the link and other physicians. The Harvard research team proposed a larger number of potential links and, afterwards, the actual links were determined on the basis of bilateral and multilateral discussions among specialties. Although we have the capability to re-link the specialty scales after deleting some links, as was proposed by commenters, we are not confident that this process would result in improved RVUs. Furthermore, we believe there are two strong arguments for not revising the links based on comments:

- Financial impact bias. The links selected in the Harvard small group process before their effects were known are less subject to the bias that they acquire when the financial impact of the selection of the link is apparent. The link services were selected before the financial impact of the choice of links was obvious to the physicians selecting the link and, therefore, we believe the

Harvard links should have less financial impact bias.

The commenters, however, are biased by the knowledge of the impact of the links on physician payment for the specialty. We believe any link changes we may make at this point, based upon public comment after the publication of proposed RVUs and the CF, might be affected by the bias of the financial impact of that change.

Evidence for this viewpoint is available from the comments themselves. Specifically, we received almost no comments from specialties identifying errors in links that advantaged them.

- Knowledge limitations. The link procedures were agreed to by representatives of both specialties after discussion of the detail of the procedures performed by the other specialty. Many physician services have become extremely specialized and physicians sometimes do not know the work effort required for services typically performed by other specialties well enough to value it. Selection of a link requires each specialty to value both its service and the service in the other specialty to which its service is being linked.

The face-to-face meetings that were held to discuss potential intra-specialty links included necessary education and detailed description of the services by each specialty and were essential to the selection of the best links by both specialties. Physicians who did not participate in this multilateral process would not be as able to evaluate the services in another specialty as the physicians who participated in the process.

Because of the process used to identify links, we do not believe it is appropriate for us to break links on the basis of individual specialty comments. Instead, we believe links should only be broken on the basis of a process that is as careful and bilateral as the process that was employed by the Harvard research team.

For these reasons, we believe the intra-specialty links used by Harvard are the most valid intra-specialty links we could use at this time to link specialties to a common RVU scale for purposes of establishing the initial RVUs.

[Medicare Adjuster]

Comment: A number of commenters have argued that a special Medicare adjuster should be added to the relative work values since the vignettes used by Harvard do not always pertain to

Medicare-age patients and sometimes refer to younger patients.

Response: We believe this issue warrants additional examination on a code-by-code basis. At this time, we are not adjusting any work values for services valued on the basis of vignettes for younger patients.

[Compression of RVUs]

Comment: On the basis of studies funded by specialty societies, commenters have questioned whether the RVU scale for work is compressed, that is, whether high valued work codes are undervalued while simpler codes are overvalued.

Response: As previously discussed, we have analyzed each of the studies submitted to us. We concluded that the use of different methodologies will usually yield different results. Thus, it is not surprising that results of these studies, which did not fully employ Harvard's methods, are at variance with the RVUs for work that were derived in the Harvard study. We have also identified a number of face validity problems that resulted from these other studies. Within the range of services included in these independent studies, some studies have overall results which were more compressed than those in the proposed rule, while others have results that appeared less compressed. Therefore, we have been unable to make a generalization as to whether compression exists in the work scale. Rather, we dealt with compression on a code-by-code basis. If a comment or study suggested that a proposed value was wrong, we reviewed that value with the CMDs.

We also referred these comments to Harvard for review and response. Harvard believes these independent study results generally lack face validity. For example, Harvard stated that the pre-work estimates in the Abt (thoracic) and Battelle studies are generally inflated due to the methods they used to estimate pre- and post-work. Also, Harvard stated that the intensities for pre- and post-work in the Abt and Battelle studies are too high, often equaling and sometimes exceeding that for the surgery itself. Harvard also observed that the intra-work scales are compressed in the Abt (thoracic) and Health Policy Alternatives studies because they used reference procedures that were high in the relative range of work.

d. *Other methodological issues.* In this section, we discuss a number of specific comments that were submitted on a variety of issues on the development of RVUs.

[Intra-Service Time Differences]

Comment: Some commenters used data from operating room logs to show that intra-service time estimates that have been used in the Harvard study differ from the commenters' information.

Response: As part of their study, Harvard also often collected operating room time logs from numerous medical centers and community hospitals. In analyzing these data, Harvard found that there is substantial variation in surgeon operating time.

Harvard stated that the commenters' time data were consistently in the upper end of the comparable data that Harvard collected. We did not change any proposed relative work values on the basis of this comment.

[Pre- and Post-Service Work Estimates]

Comment: One commenter has expressed concern about the pre- and post-service work estimates and definitions of packages for global services. Based upon data and surveys of physicians, this commenter developed work patterns for a number of surgical procedures and generated pre- and post-service work estimates for approximately 160 services.

Response: We are not using the results of this analysis for a number of reasons:

- (1) Pre- and post-service work estimates were given for only a small proportion of the 4,000 surgical codes;
- (2) The source of these values admitted that perhaps they should not be used;
- (3) The work values for visits in the global package are not consistent with those that we used; and
- (4) The method produced results that have some face validity problems.

e. *Overview of process of changing RVUs.* We used a process involving our CMDs to provide RVUs for codes for which Harvard had not furnished values and to respond to comments regarding individual values and groups of values.

There are approximately 6,000 codes for which physician work RVUs must be established. Of this number, approximately 250 are anesthesia codes whose RVUs are based on the ASA RVS. There are approximately 575 radiology codes whose RVUs are based on the ACR RVS. We have received to date approximately 4,300 RVUs from Harvard. It was necessary for us to establish work RVUs for the remaining codes (that is, new services, low volume procedures, and for other services for which a work value was not received from Harvard).

In addition, there were about 1,000 proposed work RVUs for which we

received comments. The CMDs were asked to assist us in our evaluation of the comments and to recommend changes if appropriate. We encouraged CMDs to consult the specialists they use as expert consultants in their work.

A number of meetings were held to identify which procedures seemed to be misvalued and to arrive at more appropriate values. Before describing the results of this review, several points must be noted:

- The objective of the effort was to fill gaps in the Harvard scale and to make some refinements where seeming face-validity of the value was lacking. It was not to try to "redo" the Harvard study in a short time frame. As stated above, the establishment of this process should not be interpreted as a criticism of the Harvard team. When one looks at the total RVU system, there were only modest changes. As a matter of fact, the total net change in work RVUs in comparison with values furnished by the Harvard study was about 1 percent.

- The CMDs represented a good cross-section of specialties. However, every specialty was not represented. In many cases, however, the CMDs consulted with experts to fill voids in their knowledge whenever possible. Given the realities of the time constraints, however, we believe the process has produced an improved scale by eliminating certain anomalies and by filling the gaps for missing values.

A description of our overall procedure for dealing with comments on RVUs follows:

- We submitted the codes with missing values and the codes with disputed values to CMDs and asked them to provide recommended values. We also provided a list of "benchmark" procedures that are commonly performed and for which RVUs were not subject to questions or criticism. These "benchmark" procedures were used in reviewing the appropriateness of RVUs assigned by Harvard to procedures in question and in developing missing RVUs. When comments were based primarily on clinical arguments, we supplied those arguments to the CMDs, whom we considered expert in evaluating clinical arguments related to payment. When comments were based primarily on surveys or methodological arguments, we did not provide those arguments to the CMDs because we judged that they had no special expertise in evaluating them. However, we did ask them to review the values of all codes identified in the special studies that were significantly different from the values proposed by Harvard.

- We asked each CMD to provide a value for each code where we had identified the RVUs as under scouting. These values were returned by mail, collated, and then submitted to panels of CMDs who met face-to-face. In each case, the panels either recommended retention of the Harvard value or recommended a new value. About 25 CMDs participated in these meetings.

- We did not ask CMDs to recommend values for pre-, intra-, and post-work because dealing with those subdivisions of work proved very complex and inconsistent with the abbreviated schedule within which it was necessary to work. Instead, we asked them to supply a value for total work.

- When a single value was identified as in need of correction, the CMDs were generally asked to identify a reference procedure that they used in arriving at the new value.

- When a pair of values was identified by commenters as being incorrectly related, the CMDs reviewed the relationship and recommended appropriate changes.

- When multiple values were identified by CMDs as being in need of correction, we asked them to create a matrix that would relate the values. Examples of these values follow:

- + There were many comments about the relationship of different endoscopies as well as the relation of endoscopies without and with biopsy, and without and with removal of a foreign body. The CMDs guided HCFA staff in laying out a matrix in which there was a clinically reasonable relationship for work for different endoscopies and a consistent relationship for each endoscopy among values for endoscopy alone, endoscopy with biopsy, and endoscopy with removal of foreign body.

- + A similar matrix was used to reorder values for vascular surgery. In this case, relationships were established among the basic surgeries and relationships were then established for prosthetic and vein graft techniques for each surgery.

- + A matrix was developed for cardiac surgery that related base surgeries and then within each group of surgeries related variations with and without use of a pump and with or without additional valve surgery.

- In some cases, a problem identified by a commenter necessarily led to further changes. For example, one commenter noted that the RVU for pelvic exenteration in a female (58240) was inconsistently low compared with the clinically comparable procedure of

pelvic exenteration in a male (51597). The CMDs judged that this comment was correct and recommended an increase for the procedure. We subsequently received revised values from Harvard that corrected the problem noted by the commenters and those RVUs are shown in this rule. However, during their review the CMDs noted that a number of other urologic procedures were quite high compared to other procedures on the fee schedule. The CMDs then examined all of these procedures both in comparison to gynecologic procedures and in comparison with general surgery procedures and adjusted some of the urologic procedure RVUs.

- In some cases, CMDs identified obvious errors in RVUs for which no comments had been received and recommended corrections. For example, CMDs found that in several cases that the RVU for the transplantation of a long nerve was inappropriately lower than the RVU for transplantation of a short nerve.

- After CMDs had made their recommendations the results were collated and reviewed by our staff; the group was then reconvened to re-examine recommendations that appeared to be controversial or to have high impact as well as to act on a few comments that had not been covered during the first meeting.

Further explanation of the specific changes made as a result of this process may be found in the discussion of individual code changes below. A summary of the major results of the process is as follows:

- A number of face validity problems with the Harvard work RVUs were identified and corrected (for example, 4-graft coronary artery bypass graft RVUs were adjusted to be greater than 3-graft surgery).

- Rank order problems within and across families of codes many of which were identified by commenters were corrected (for example, endoscopies).

- Work RVUs for some complex services thought to be undervalued were increased (for example, some vascular procedures), whereas the RVUs for some less complex procedures were lowered.

Finally, we established some work RVUs through charge-based extrapolations or on the advice of our medical staff for codes for which neither Harvard nor the CMDs reviewed.

f. *Changes in work values for "starred codes".* In the proposed rule, we published values for a number of codes that are "starred" in the CPT; that is, they are relatively minor procedures that might be performed during an office

visit. If performed in an office setting, an office visit must not be billed in addition to the procedure unless services unrelated to the procedure are furnished.

In the proposed rule, the work values for starred procedures were for the "intra" work alone, the work by the physician actually performing the procedure. The proposed rule values did not include immediate pre- and post-work (work before and after the procedure, including possible time with the patient, on the day of the procedure) or follow-up work (work associated with follow-up visits). The values published in this final rule include pre- and post-work and follow-up work as applicable.

The intra-work values were almost all furnished by Harvard; CMDs advised us on filling some gaps (for example, Destruction of an extensive lesion of the penis) and modifying some values (for example, the value for 57451, Culdoscopy with biopsy, was increased). In a few cases, we further modified intra-work values to make them consistent with values for other procedures (for example, 57450, Culdoscopy, was increased to be consistent with 57451, Culdoscopy with biopsy, which was increased on advice of the CMDs).

The immediate pre- and post-values were generally supplied by Harvard, but, with the assistance of our medical staff, we filled a substantial number of gaps and modified some values. There were 3 reasons for modification:

- Some values appeared to have been produced by a formula and not to follow clinical practice: For example, we judged that there were no immediate pre- and post-services associated with CPT code 36000, Introduction of needle or intracatheter, vein.

- Some values showed variation that appeared to result from surveying small numbers of physicians. It was our judgment that it was appropriate to simplify the product by providing a standard number for a family of procedures. For example, most procedures involving casts were assigned a value of 33 (on Harvard's scale), which was the average number from Harvard's data and the number we assigned to the large number of gap-filled values.

- In some cases pre- and post-values were inferred from a value for total work furnished by the CMDs.

The follow-up work values were those for a single office visit for an established patient, generally level 1, 2, or 3. For each surgical code, we assigned the visit level that corresponded to the general levels of follow-up work furnished by

Harvard. We did not include a follow-up visit in the work value for services for which a global period of 0 days was assigned.

The assignment of global values and their meaning is discussed elsewhere in this preamble. The global period shown in addendum B of this final rule indicates whether a procedure is subject to a global period. The CPT assignment of a star to a code has no specific meaning for Medicare payment.

g. Detailed discussion of RVU changes. In the remainder of this section, we provide responses to comments on the work values of frequently performed services, particularly those comments resulting in substantial changes. The methods for reaching these decisions are described earlier. Most changes were made with the advice of our CMDs in response to comments received on the proposed rule. Some changes were responsive to anomalies noted by CMDs when evaluating codes in response to a related comment. Other changes were made by our medical staff to make RVUs consistent with our final global surgery policies or with other coding and payment policies established in this rule.

We will address the major issues in the order of the codes as they appear in the CPT (infusion therapy, psychiatry, medical services, anesthesia, dermatology, orthopedics, cardiovascular, general surgery, endoscopy, urology, gynecology, neurosurgery, ophthalmology, otolaryngology, radiology, and pathology). We conclude with a discussion of transplant surgery and services that are reported using alphanumeric HCPCS codes.

[Infusion Therapy—Codes 90780 Through 90781]

Comment: Several commenters expressed concern about payment under the fee schedule for outpatient intravenous infusion therapy. Commenters noted that the proposed rule did not address the way we would pay under the fee schedule for infusion therapy other than for cancer chemotherapy. Commenters stated that we should pay separately for this infusion therapy and that payment should recognize the costs of prolonged infusion therapy in physician offices (for example, nursing costs, supply costs, and equipment costs), and that we should clarify that visits may be paid in addition to the infusion therapy.

Response: We agree that infusion therapy for purposes other than cancer chemotherapy should be separately payable. The values that are presented

in this rule for codes 90780 and 90781 are based on current national average allowed charges for Medicare. We do not believe these codes include physician work, since the services are virtually always performed by personnel under the supervision of a physician. The services are essentially covered only as "incident to" services in physicians' offices. Payment for these services in a hospital setting will not be made and claims for these codes with a 26 modifier will not be recognized. A physician may, of course, bill for a visit if significant, separately identifiable services are furnished on the day of the infusion.

[Psychiatry—Codes 90801 Through 90899]

Comment: Several commenters expressed concern that the proposed fee schedule for psychiatric services was inaccurate and that the primary anomaly for psychiatry was the general discounting of the importance of time in establishing RVUs for psychiatric services.

Response: We reviewed the issue of psychiatric services with our CMDs who agreed that for psychiatric services, time was an important determinant in establishing RVUs for work. To help set the value, they looked to values for other comparable services, namely visits. Code 90801, psychiatric diagnostic interview examination, was increased in value based on a comparison to a 60-minute office visit with a new patient. Codes 90843 and 90844, individual medical psychotherapy, were also increased in value based on a comparison to the work involved in office visits of comparable duration. We will not pay for code 90841, which is the code for individual psychotherapy with the time unspecified, under the fee schedule, because of our difficulty in establishing an RVU for this service whose time is, by definition, unspecified. The CMDs recognized that the pre- and post-work associated with individual medical psychotherapy may not be as great as the pre- and post-work associated with other visit services because of the nature of the long-term relationship that is established between the physician and patient. However, the increase in values was considered appropriate given the fact that more medical documentation and ordering activities are performed during the intra-period.

The CMDs recommended and we agree that an individual psychotherapy code can be used for a patient who is hospitalized but that an inpatient hospital visit code cannot also be used on the same day. Likewise, the initial

hospital care furnished to a patient admitted for a psychiatric problem may be reported with either code 90801, psychiatric diagnostic interview examination or with a code for an initial hospital visit, but not both. We recognize this policy may not be consistent with the introductory notes to the psychiatric section of the CPT. At the present time, however, there is considerable variation across carriers in their policies regarding payment for hospital care and psychiatric care on the same day of service. If the CPT codes are revised in the future, we will reconsider revising RVUs to be consistent with the new or revised codes. Given the increase in values which we have made, we believe our policy will be fair. The CMDs also recommended an increase in RVUs for code 90853, group medical psychotherapy, which we accepted. The value represents the work associated with a single patient in a group psychotherapy session, not the work associated with the entire group.

[Dialysis—Codes 90935 Through 90947]

Comment: Several commenters expressed concern that the work RVUs for dialysis codes that were presented in the proposed rule were undervalued because they did not include the appropriate amount of pre- and post-work in a total work value. They recommended that the values be increased by 16 percent to be consistent with the Harvard data.

Response: We forwarded these comments to Harvard for their review and based on their response that the commenters were correct, we have increased the RVUs for these services in this final rule. If, however, a patient receives hemodialysis or peritoneal dialysis in a hospital setting, payment for a hospital visit on the same day that dialysis is performed generally will not be made.

[Ophthalmology—Codes 92002 Through 92499]

Comment: Several commenters noted that the relationship between the value of a comprehensive visit for a new patient (code 92004) and a comprehensive visit for an established patient (code 92014) was inconsistent with the relationship between new and established patients in all other visit services. Specifically, the value of the comprehensive visit for a new patient in the proposed rule was very close to the value of a comprehensive visit for an established patient for ophthalmology services.

Response: Our CMDs reviewed this issue and increased the value of code 92004 to make the relationship to the established comprehensive patient visit (code 92014) comparable to that for other visit services. In addition, we received recommended work RVUs from our CMDs regarding a number of other ophthalmology services for which values were not furnished by Harvard. The values shown are based on the assumption that the codes describe bilateral services. Therefore, additional payment will not be made for claims that are submitted with a bilateral modifier. If a diagnostic service is performed on only one eye, then the reduced service modifier should be used.

[Special Otorhinolaryngologic Services—Codes 92502 Through 92599]

Comment: Questions raised about the codes in this section were primarily related to the fact that many of them had not been surveyed by Harvard and consequently values were not presented in the proposed rule.

Response: Our CMDs recommended values for many of these services and based their recommendations on other comparable diagnostic or visit services. Three codes in this series (92531 through 92533) have been assigned a work value of zero because we believe these codes represent services that are ordinarily furnished as part of a history and physical examination. The values for the audiologic function tests (codes 92552 through 92596) are based on historical charges and represent the technical component of services only, because they are not considered to be professional physicians' services.

[Cardiovascular—Codes 92950 Through 93799]

Comment: The vast majority of comments on the cardiovascular codes in the CPT were focused on electrocardiograms. By law, payment may not be made for the interpretation of an electrocardiogram that is ordered or performed in conjunction with a visit or a consultation. This issue is discussed in more detail elsewhere in this final rule. Although we did not receive many comments on the work RVUs in this section, changes have been made to the work values of certain high volume services in this section and an explanation of these changes is furnished below.

Response: The following changes were made to cardiovascular service values:

Cardioversion. Cardioversion, code 92960, was determined not to have a global period. The value was adjusted

by subtracting the values for follow-up visits. This change, however, should not be viewed as a reduction in total payment since follow-up visits may be billed separately.

Thrombolysis. We have published in this final rule a work RVU of zero for thrombolysis by intravenous infusion (code 92977), because we believe this service does not involve physician work. The value which is shown in this final rule is a charge-based value for practice expense and malpractice expense. Payment will be made for this service only if it is furnished to a patient outside a hospital setting.

Diagnostic cardiovascular procedures. For many of the diagnostic services in the cardiovascular section, three codes are presented. The first code generally describes the performance of the test and its interpretation. The second code describes the performance of the test only, and the third code describes the interpretation and report only. The single code for performance and interpretation should not be used with a 26 or a technical component modifier.

For example, code 93015 is the complete procedure code for cardiovascular stress tests, code 93017 must be used to bill the tracing only, and code 93018 must be used to bill the "interpretation only" service. In some areas of the country, however, code 93015, with a 26 modifier, has been used to report the interpretation and report. The 26 modifier might be used with code 93015 to describe direct physician involvement in the performance of the test as well as an interpretation and report. We are concerned that the 26 modifier is being used incorrectly by many physicians who are performing an interpretation and report only and reporting their services using code 93015 with a 26 modifier. Beginning in January 1992, we will no longer make payment for code 93015 with a 26 modifier or for any other code that has a separate interpretation-only code.

Code 93201, phonocardiogram, reads as follows: "phonocardiogram with ecg lead; with supervision during recording, with interpretation and report". We believe this code is clear and have valued the service to include the supervision that takes place during the recording. It may be necessary to delete, revise, or add new CPT codes for other cardiovascular diagnostic tests that currently are described by multiple codes.

We have established a value for doppler color flow velocity mapping, code 93325, based on historical charges. This code represents a technical service only. The physician work involved in

interpreting color flow velocity mapping is included in payment for the basic echocardiographic procedure, which is listed separately in addition to this code.

Cardiac catheterization. The cardiac catheterization codes in the series 93501 through 93529 include the introduction, positioning and re-positioning of catheters, the recording of intra-cardiac and intra-vascular pressures, the obtaining of blood samples for measurement of blood gases and cardiac output. These codes do not include angiography. The introductory note to this particular section of codes in the CPT states that cardiac catheterization includes final evaluation and report. This should not be interpreted to mean that codes 93501 through 93529 include the interpretation of angiographic films associated with cardiac catheterization procedures, because cardiac catheterization codes involving angiography are in a separate section to which these notes do not apply. For the cardiac catheterization codes in the series 93546 through 93553, we interpret the codes to include the introduction of a catheter, placement or re-positioning, and injection of the contrast media or dye. We believe the work RVUs we received from Harvard included the work of interpreting the films.

To avoid duplicate payments, we have adjusted the values for the cardiac catheterization codes to remove the values for angiographic interpretation. We would expect, however, that when a cardiologist performs a cardiac catheterization and also provides the interpretation of that procedure, he or she would report the services using the cardiac catheterization codes and the radiology supervision and interpretation (S&I) codes. In those areas where the cardiologist performs the cardiac catheterization and the radiologist performs the interpretation, the cardiologist would use the cardiac catheterization code only and the radiologist would use the radiology interpretation code only. In addition to changes in values that were made to be consistent with this standard policy, we also adjusted values for the codes in the series 93546 through 93553 to make them consistent with the values that are associated with the component parts of these procedures. For example, code 93547, combined left heart catheterization and selective coronary angiography and selective left ventricular angiography, is a code that is used when procedure 93510 is combined with procedures 93543 and 93545. The values presented in the proposed rule, which were inconsistent with the

additive nature of these combined codes, have been revised.

[Non-Invasive Vascular Studies—Codes 93875 Through 93979]

Comment: We received no comments on these specific codes since they will be new codes in 1992.

Response: The work RVUs in this rule were developed based on recommendations from the CMDs. Our payment policies regarding these codes follow:

- No payment will be made for the use of a simple hand held or other Doppler device that does not produce hard copy output, or that produces a record that does not permit analysis of bidirectional flow since this is considered to be part of the physical examination of the patient.
- All procedures are valued based on an assumption that the procedures are bilateral.
- If payment is made for a duplex scan, separate payment on the same day of service will not be made for non-invasive physiologic tests.

[Pulmonary—Codes 94010 Through 94779]

Comment: Commenters stated that the physician work RVU for 94010 should be twice the work value for 94060, because 94060 represents the work of interpreting two spirometers to determine whether or not significant changes have occurred and whether or not evidence of bronchospasm is present. Commenters noted that the technical component RVUs are doubled, and cite this as evidence that the work RVUs should also be doubled.

Response: We agree that there is more work in 94060 than in 94010, and we have raised the value. However, we did not double the value because we do not believe the pre- and post-work is also doubled for 94060. We also established a value for 94070 (prolonged postexposure evaluation of bronchospasm) (for which we did not have a value in the proposed rule) at twice the value for 94060.

[Allergy and Clinical Immunology—Codes 95000 Through 95199]

Comment: Commenters stated that the RVUs for CPT code 95150 (professional service for the supervision and preparation of antigens for allergen immunotherapy) should be based on a payment per dose and that this principle should apply to all the immunotherapy codes. Commenters stated that the RVU payment that equated to a payment of approximately \$19.00 does not seem consistent with a per dose payment or with a payment per vial, which is

typically 10 doses. Commenters also stated that many patients receive injections from the primary care physician rather than the allergist and that many allergists who give the therapy bill for both the cost of the antigen (codes 95135 through 95170) and the professional service in providing the injection (code 95115 or 95117), rather than billing for the immunotherapy including the antigen (codes 95120 through 95134). Commenters stated that the different billing practices and different payment practices that exist across the country cause there to be no reliable data nor uniform practice upon which to base charge based RVUs for these services. Commenters suggested that allergy testing, and immunotherapy services be excluded from the fee schedule for these reasons, and that antigens be excluded from the fee schedule because they are covered under section 1861(s)(2)(G), which is not included in the law's definition of "physicians' service" for purposes of the fee schedule.

Response: We have established new initial RVUs for allergy tests, and payment will be made on a per test basis. We will prepare instructions to carriers to ensure uniformity in billing and payment for these services. We have not excluded allergy testing services from the fee schedule, but we agree with the commenters that antigens are not included in the fee schedule. Therefore, we have not included codes 95120 through 95170 in the fee schedule.

Comment: Commenters stated that there should be physician work included in the RVUs for allergy testing and that the physician work in the allergy test is distinctly different from the work in a visit. They believe the RVUs shown for practice expense and malpractice expense for allergy testing should be maintained, but that RVUs should be added for physician work.

Response: We do not agree that there is physician work in the performance of allergy testing. This testing is generally performed by staff under a physician's supervision. We believe the RVUs for these procedures should reflect that the resources are practice expense and malpractice expense only. The physician work of taking the history, performing a physical examination, deciding upon the allergens to be tested based upon the history and the findings of the examination, the interpretation of the tests (as distinct from the reading of the tests), counseling and the prescription of the course of treatment, if needed, are all evaluation and management services that will be compensated as part of the visit or consultation for which the physician is paid.

[Chemotherapy Administration—Codes 96400 to 96549]

Comment: We received numerous comments on the issue of chemotherapy administration. Most of the comments focused on our proposed payment policy for drugs and our proposal to prohibit payment for visits on a day when a patient received a chemotherapy injection.

Response: The issue of payment for drugs is addressed elsewhere in this final rule. We have accepted the argument that it would not be appropriate to apply our proposal to prohibit payment for a visit on a day when a chemotherapy injection is administered. We agree that chemotherapy administration is a more complex service than other simple injections. Consequently, visits may be billed on the same day as chemotherapy administration so long as they are documented and separately identifiable.

The values that are presented in this rule for codes 96400 through 96425 are based on average allowed charges across the country. We do not believe these codes include physician work, since the services are virtually always performed by personnel under the supervision of a physician or by hospital employees. Payment will not be made for these chemotherapy administration services in a hospital setting and claims for these codes with a 26 modifier will not be recognized.

Separate payments will be made for each chemotherapeutic agent furnished on the day of chemotherapy administration. These drugs are billed through the use of alpha-numeric HCPCS codes. If multiple drugs are furnished separately, only a single chemotherapy administration code should be used. Therefore, only one "push" technique code may be reported when multiple drugs are furnished by this technique. Likewise, if chemotherapy administration for one drug is by infusion technique and for another drug is by push technique, payment will be made only for the infusion technique code.

There are three codes in the chemotherapy section that do involve physician work. Those are codes 96440, 96445, and 96450, which describe chemotherapy administration into the pleural cavity, the peritoneal cavity, and the central nervous system, respectively. The final work values for these codes were based on the recommendations of our CMDs who interpreted the codes to include the performance of thoracentesis, paracentesis, or lumbar puncture. That is, separate payment will

not be made for the performance of these procedures, since the chemotherapy codes themselves are valued to include the services.

[Anesthesiology—Codes 00100 Through 01999]

Comment: One commenter expressed concern that for anesthesia, pre- and post-service work estimates were based on responses to only three codes and do not reflect the variation in work for that specialty.

Response: Although payment for anesthesia services is not directly based on the Harvard values, it is important to understand how the Harvard values were derived since those values were used in linking the ASA scale to the other services on the fee schedule. Anesthesiology was studied in Phase I of the Harvard study. Pre- and post-service work estimates were derived using a multi-step process. First, physicians were surveyed for estimates of pre- and post-service times for the three services in question. Then, regression techniques were used to generate time estimates for the remaining services. Next, direct ratings of work and time for a sample of services from all specialties were used to generate pre- and post-service intensity for all services. These estimates were multiplied by the time estimates to generate pre- and post-service work estimates. The work estimates were subjected to review by a Technical Consulting Group. They believe the results have face validity. Furthermore, Harvard found them to be consistent with those of the RVU scale developed by the ASA.

[Subcutaneous and Areolar Tissues—Codes 10040 Through 19499]

Comment: Numerous comments were received regarding a wide number of codes in the dermatology section of the CPT. Some commenters objected to the RVUs for excision of skin lesions. Specifically, they stated that the physician work for many CPT codes in the range from 11100 through 18000 is undervalued and that these codes should be resurveyed before the values are implemented because the impact of using these values would be very adverse to physicians. Some commenters stated that the work values for these procedures seemed to be proportional to the size of the lesion and did not pay sufficient attention to the location of the lesion on the body (for example, face versus a less visible location) or to the number of follow-up visits typically furnished. Commenters stated that the Harvard estimates of pre- and post-service work per minute vary

across dermatological procedures and that, therefore, the methods and data that were used to calculate the proposed values are unreliable. Commenters also argued that the estimates of post-procedure visit times were substantially undervalued and, therefore, the physician work RVUs are understated. Commenters asked that these services be excluded from the fee schedule and continue to be paid on a reasonable charge, basis unless they are resurveyed before the fee schedule is implemented.

Response: Because so many codes were questioned, our CMDs carefully reviewed the entire section. Some problems were noted with the RVUs of some codes on which comments were not submitted. In addition, there are many codes in this section of the CPT which are considered "starred" procedures. We have added pre- and post-work values to these codes with a resulting increase in the RVUs. A discussion of the addition of pre- and post-work values to "starred" procedures is addressed elsewhere in this preamble. To facilitate the reader's understanding of the changes that have taken place in this section of the CPT, our response below will address the codes in order.

Debridement. The CMDs concluded that the work values for the debridement codes (11000 through 11044) were significantly overvalued relative to the amount of work that they believe is associated with these services. Consequently, the value has been reduced.

Likewise, the CMDs advised us that the values for the debridement of nails (codes 11700 through 11711) were too high. We discussed this issue with the Harvard study team, and they agreed that since these procedures are predominantly performed by podiatrists the work estimates they obtained from general surgeons may not be appropriate. Therefore, Harvard withdrew their values and we are substituting charge based RVUs for our initial values.

Lesion excision. We have not changed the work values for the lesion excision codes, because we believe these surgical services are properly valued. The Harvard research team acquired direct estimates of the intra-work, and the immediate pre- and post-work for these services during its in-depth review of these services; no imputations or assumptions were involved in these estimates of work. The standard errors for these estimates were consistent with the estimates for other surveyed services. Moreover, the estimates of post-service visit time that were

furnished by commenters were the results of a consensus process which has been shown to result in higher values than a national random survey.

For destruction of skin lesions, a new series of codes have been added to the CPT for the reporting of destruction of malignant lesions. Values for these codes (17250 through 17286) are based on Harvard research, which indicates that the work of destroying malignant lesions is about 80 percent of the work of excising malignant lesions.

Mohs' surgery. Many comments were received regarding a service known as Mohs' micrographic surgery, which is a type of surgery performed on skin cancers. It was argued that the work RVUs for these procedures should be increased on the basis that the Mohs' technique has both surgery and pathology components. Our CMDs reviewed this issue and agreed that the values as presented in the proposed rule were inconsistent with the amount of work associated with this service. Consequently, we have raised the values. Commenters also expressed concern that many carriers do not currently accept second, third, and additional stages of this procedure as separately billable services; that is, providers are being subjected to a multiple procedure rule that results in a reduction of payment when these second, third, and additional stages are submitted. We agree with the commenters that these codes should be treated as additional codes and not subjected to multiple procedure rules. The values for codes 17305, 17306, and 17307 have been made the same. Finally, code 17310, which is described as "Mohs', more than 5 specimens, fixed or fresh tissue, any stage", should be treated as a single specimen; that is, if more than 5 specimens are necessary at any stage, each additional specimen beyond 5 should be separately paid. The work RVUs have been established according to the above interpretations.

[Musculo-Skeletal System—Codes 20000 Through 29909]

Comment: We received some general comments that the values for orthopedic procedures may not be accurate due to the potential for "compression." No specific codes were cited with this comment. One commenter suggested that the spinal instrumentation codes appeared to be overvalued. Several commenters expressed concern that the values for treatment of closed fractures or dislocations without manipulation were significantly overvalued and recommended that the payment for these services be based on visit codes

only. Other commenters stated that RVUs for certain podiatric procedures such as correction of a bunion or revision of hammertoe are too low.

Response: Because of the concern raised about the possibility of compression (which we interpret as meaning complex procedures may be undervalued and less complex procedures may be overvalued), our CMDs reviewed all of the codes in this section. In general, they found that the majority of codes were properly valued and no changes were made. In a few circumstances, upward or downward adjustments were made but those changes were relatively minor. We did not change the RVUs for any bunion or hammertoe procedures, because our CMDs advised us that the values that were given in the Harvard study were appropriate relative to the rest of the scale and relative to each other.

There were a large number of codes in this section that were new in 1990 or 1991 and for which we did not receive work values from the Harvard study team. The largest section of these were for maxillofacial procedures. Because these services are rarely performed on Medicare beneficiaries and because the work may vary from patient to patient, our carriers recommended and we agreed that these codes should be priced by the carrier.

We reviewed the spinal instrumentation codes (22840 through 22845) and noted that the values we received from Harvard included pre-, post-, and follow-up work. Because these codes are listed separately in addition to the code for fracture dislocation or arthrodesis of the spine, we do not believe pre-, post-, and follow-up work is appropriate for these codes. Consequently, these pre- and post-values were removed which resulted in a reduction in the work RVUs. We believe this change responds to the observation of the commenter who believes they were overvalued.

There are approximately 50 codes in the musculoskeletal system section of CPT for reporting closed treatment of fractures or dislocations without manipulation. One example is 22310, closed treatment of vertebral body fractures, without manipulation. The CMDs agreed with the general comment that these codes for fractures appear to be overvalued and that a visit rather than a surgical service was the proper coding vehicle. For the present time, however, we have decided to continue to treat these codes as surgical services, rather than visits. We did, however, review the intra-service work values that we received from Harvard, and based on the recommendation of our

medical staff, we have reduced the intra-service work portion to a level comparable to that for applying a cast or a splint. This change has led to a reduction in the values of these codes, but not to the levels suggested by the commenters.

[Respiratory System—Codes 30000 Through 32999]

Comment: Two commenters indicated that emergency tracheostomy (31603 and 31605) should have a higher RVU than planned tracheostomy (31600 and 31601) and that RVUs for procedures in this family had inappropriate relationships. With the exception of these codes, we received relatively few comments on the values in this section, other than procedures whose values were questioned as a result of a study performed on behalf of the Society of Thoracic Surgeons and a number of vascular surgical specialty societies.

Response: We agree that the values for tracheostomies shown in the proposed rule had an inappropriate relationship. The RVUs shown in this rule, however, have been lowered for the emergency procedures because we removed post-work values after we decided not to subject these procedures to a global period. Follow-up visits during the post-operative period for emergency tracheostomies may be billed separately. For planned tracheostomies, we have retained post-work values because these procedures will be subject to a 90-day global period and follow-up visits will not be paid separately. Our CMDs carefully reviewed the remaining codes in this section and found most values to be appropriate. If changes were made, they were usually made to major thoracic procedures. Recommendations for changes were based on the comparison of the work associated with a given procedure to the baseline procedure of 32100, thoracotomy, major; with exploration and biopsy. For example, the value for code 32500, "wedge resection of lung, single or multiple", was considered to be more work than a thoracotomy and the value was raised accordingly. On the other hand, the CMDs believe code 31585, "treatment of closed laryngeal fracture without manipulation" involves less than half the work of a major thoracotomy, even though the Harvard value was 3 times that of the major thoracotomy. We believe this may have occurred because of the low frequency with which this service is furnished. Nonetheless, because of the discrepancy, the value has been lowered for this final rule.

The CMDs expressed some concern that the endoscopic sinus procedures, as

well as the open sinus procedures, appear to be overvalued relative to other services on the fee schedule. We believe this is an area where further review will be necessary during the transition.

[Cardiovascular System—Codes 33010 Through 37799]

Comment: Commenters objected to the physician work RVUs for virtually all cardio-thoracic surgery services as being improper. Commenters stated that the proposed rule values for these services have been severely compressed and truncated by the overvaluation of relatively minor procedures in conjunction with the systematic undervaluation of many intermediate and most major operations. Commenters presented examples of cases in which the values for these services lacked face validity (for example, a 4-graft bypass procedure was valued less than a 3-graft procedure). They also presented an independently performed study, which concluded that the majority of the codes considered by the studies have work RVUs that are discordant by a factor of 15 percent or more. Commenters asked that we either revise the scale to correct the problems the study identified, or if that is not possible, adopt the values from the independent study for these services.

This section of CPT also includes a number of vascular injection procedures that are frequently performed by interventional radiologists. We received a study from the Society of Cardiovascular and Interventional Radiology (SCVIR) that addressed many of the codes in this section. Other commenters objected to the RVUs for physician work in placing single and dual chamber pacemakers. They stated that placement of a dual chamber pacemaker is a much more complicated procedure than the placement of a single chamber pacemaker and the lack of adequate payment would result in many physicians selecting the simpler procedure and spending less time in the operating room, causing the quality of patient care to suffer.

Response: The CMDs reviewed virtually every code in this section. Many of the changes that they recommended did not involve significant changes in work values, but rather involved a re-ordering of the relative work of procedures within a given family. The CMDs also recommended that more consistent rules determine the RVUs for vascular procedures that involve grafts of one type or another. Consequently, in many areas, a fixed amount has been added to the base

procedure to account for the additional work involved with a graft. To give the reader an understanding of the changes that were made based on the recommendations of the CMDs, the following examples, which were also cited as examples of problems by commenters, will serve to illustrate the changes that have taken place in this section.

Commenters noted that the proposed rule work value for carotid endarterectomy (code 35301) was less than twice that for simple carotid exploration or ligation despite the fact that an endarterectomy requires arterial control, formal endarterectomy, and precise closure that often necessitates the application of a patch. The CMDs agreed and raised the value of 35301.

Commenters noted that the work values in the proposed rule for in situ vein grafts were less than the work for prosthetic grafts. It was argued that the preparation of either reversed or in situ vein grafts requires considerably more intra-operative work than is the case with prosthetics, and that complications related to the counter-incisions used to harvest them may in certain patients require additional work during the post-operative period. The CMDs agreed with this point and have made revisions to the work values of the prosthetic, reversed, and in situ vein graft codes in this section.

Commenters noted that the four codes describing the surgical treatment of portal hypertension appear to be significantly undervalued in light of the fact that there is substantial work during the entire peri-operative period, and patients who require portal decompressive operations often present with massive hemorrhage associated with impending liver failure and metabolic encephalopathy. The CMDs reviewed these four codes (37160, 37180, 37181, and 37145) and recommended a substantial increase in the work values.

Several commenters noted that there were some values in the proposed rule that appeared to be over rather than undervalued. For example, the work RVUs for the insertion of a temporary transvenous pacemaker catheter (code 33210) was cited as being too high. The CMDs reviewed the values and agreed with this finding. The work value has been reduced in this final rule.

Several commenters noted that there was little difference in the proposed work RVUs for the repair of an aneurysm of the aorta performed electively compared to repair of a ruptured aneurysm, which is performed on an emergency basis. The CMDs reviewed this issue and agreed that there is considerably more work in the

treatment of a ruptured aortic aneurysm and consequently the final value has been increased.

For transluminal angioplasty, we received conflicting recommendations from the two studies that were submitted on this procedure. Consequently, we met with a small group of vascular surgeons and interventional radiologists and one of our CMDs to review these codes. Based on our consultations, we determined that the work values for open procedures and the work values for percutaneous procedures, which are new codes in CPT 1992, should be the same. We also concluded that the ranking of work from least to most should be as follows: Venous and iliac; aortic; femoral-popliteal; brachiocephalic; and renal or visceral. We then established values for these procedures based on comments received that suggested the work for a renal transluminal angioplasty would be slightly more than that for a coronary angioplasty. Having set that value, we then set values for the other codes based on the same relationship as was determined by the special study conducted by SCVIR. The work values for these procedures do not include follow-up work and they are assigned zero follow-up days. This is an interim arrangement; we expect to develop global RVUs for both families of procedures. The work values also do not include the work of any separate diagnostic angiogram that is performed on the same day as the procedure. However, they do include the work of any angiographic services directly related to the angioplasty itself.

We also received comments on the vascular injection procedures (codes 36000 through 36248). The reporting of, and payment for, these services will be changed considerably in 1992, as a result of coding changes that have taken place related to these and other interventional radiology procedures. Specifically, codes in the radiology section of the CPT, which were previously used to report "complete procedures", have been deleted. Consequently, a radiologist must report performance of these procedures using a code from the radiology section for S&I and a code or codes from the surgery section to report the actual performance of the procedure. We are working with the ACR, SCVIR, and the CPT staff to develop educational materials for use by physicians and our carriers regarding the proper reporting of services. The issue is complex and will not be fully addressed in this final rule, other than to note that the values that appear in this final rule have been developed to be

consistent with the basic coding guidelines.

For pacemaker procedures, we reviewed the proposed values as well as the recommended values that were submitted with the study performed for the Society of Thoracic Surgeons. That study suggested that the pacemaker procedures were overvalued, which is contrary to other comments we received. We decided not to change the values at this time other than to increase the value for code 33207 based on a revised work value received from Harvard after publication of the proposed rule.

[Hemic and Lymphatic Systems—Codes 38100 Through 38999]

Comment: We received a few comments on the codes in this section regarding RVUs. Our CMDs reviewed the codes for consistency with the rest of the fee schedule and identified several instances where the values seem to be out of line. For example, a suture of the thoracic duct by thoracic approach was valued below that of a thoracotomy in the proposed rule. The CMDs believe this service was slightly more complex than a thoracotomy and recommended that the value be increased.

Response: For the two bone marrow transplantation codes, 38240 and 38241, we have accepted the Harvard values. We interpret these codes as representing the work performed in the hospital on the day when the bone marrow transplantation actually occurs. That is, it is a 1-day code only. It should not be viewed as a global service. On a day when this code is reported, however, payment for a visit will not be made because visit services are included in the RVU.

[Digestive System—Codes 40490 through 49999]

Comment: We received numerous comments on the codes in this section that describe primarily general surgical procedures as well as gastrointestinal endoscopic procedures.

Response: The CMDs reviewed the codes in this section to assure that the values are consistent with the rest of the fee schedule and to identify and correct any potential rank order anomalies. The following discussion provides examples of the types of changes that were made based on the recommendations of the CMDs.

It was noted that the values for procedures that involved radical neck dissection varied considerably depending on the type of primary procedure that was performed. The

CMDs recommended and we agreed that there should be a fixed amount for the performance of a radical neck dissection regardless of the primary procedure that is performed.

The excision of a lesion of the esophagus by thoracic approach (code 43101) was increased in value to be consistent with the values in the fee schedule for other procedures involving a thoracotomy.

The values for hemigastrectomy procedures 43630 and 43638 were increased in value, because they were viewed to be undervalued relative to the complexity of the procedure.

The codes in the digestive section for which we received the largest number of comments were those describing endoscopic procedures. Concerns were raised that the more complex procedures such as colonoscopy and endoscopic retrograde cholangiopancreatography (ERCP) were undervalued and that the relationship of comparable procedures in different families of endoscopic procedures should be consistent. For example, the performance of a biopsy should have a more fixed value across families of endoscopic procedures. We reviewed with the CMDs the information we received in response to the proposed rule and, based on their recommendations, have revalued the endoscopic procedures as follows. First, a hierarchy of work was established from the least difficult endoscopic procedure to the most difficult endoscopic procedure. The order follows: anoscopy;

proctosigmoidoscopy; flexible fiberoptic sigmoidoscopy; esophagoscopy; upper gastrointestinal endoscopy; small bowel endoscopy; colonoscopy; and, ERCP. Having established this hierarchy, the CMDs selected the Harvard value for a diagnostic upper gastrointestinal endoscopy as the baseline procedure. The other endoscopic procedures were valued relative to this service. Next, the CMDs established values for additional services that are performed across these families. For biopsies, we have added a fixed amount of 0.32 RVUs to the base procedure. For the removal of a foreign body, we added 1.07 RVUs. For the removal of a polyp, we added 1.07 RVUs. For the ablation of a tumor or mucosal lesion, or the control of hemorrhage, 2.14 RVUs were added to esophagoscopy and upper gastrointestinal endoscopy, and 1.6 RVUs were added for the lower bowel procedures (proctosigmoidoscopy, sigmoidoscopy, and colonoscopy). We believe these changes are consistent with the comments we received in that

the values for the more complex procedures of colonoscopy and ERCP have been increased.

On a related issue, we received comments that the percutaneous biliary endoscopic procedures (codes 47552 through 47555) were undervalued relative to ERCP. The CMDs advised us that those comments are correct and, given the increase, which we described above for ERCP, the increase in values for the percutaneous biliary endoscopies is considerable.

[Urinary System and Male Genital System—Codes 50010 Through 55899]

Comment: We received relatively few comments from urologists or urological associations on specific work value issues. One commenter stated that it was clinically unreasonable to have a higher RVU for prostatectomy with complete dissection (55845) than for a prostatectomy with limited node dissection (55842). One commenter stated that renal homotransplantation with recipient nephrectomy (50365) was incorrectly valued lower than renal homotransplantation without recipient nephrectomy (50360) and that both procedures were valued too low compared to donor nephrectomy (50300 and 50320). We did receive, however, comments from other physicians and associations who expressed concern that the work values of selected procedures in their specialty are undervalued relative to comparable urological procedures. For example, code 51597, which is used to report the removal of pelvic structures in a male, had a work value in the proposed rule that was greater than 50 percent higher than a comparable procedure in gynecology (code 58240), which is used to report the removal of pelvic structures in a female.

Response: The CMDs agreed with the comment regarding the prostatectomy procedures and we have revised the values to give a higher value to a complete dissection than a limited dissection.

The donor nephrectomy codes were listed in the proposed rule inadvertently. These procedures are not on the fee schedule. Payment for these services is made under Part A as organ acquisition costs. The CMDs, however, agreed that renal homotransplantation with recipient nephrectomy (50365) should be valued higher than renal homotransplantation without recipient nephrectomy (50360). The RVUs in this rule have been revised accordingly.

The CMDs agreed with the assessment of some commenters that the work values in urology appear to be overvalued relative to other services on

the fee schedule. We are unable to resolve the issue of whether the urological scale is out of line with other services on the fee schedule in time for this final rule. We plan to refine these values during the transition, and we would appreciate comments concerning these issues from interested clinicians and specialty societies.

While we did not undertake a systematic and complete review of the RVUs for urological procedures, the CMDs did identify a relatively small number of procedures for which they recommended changes in values for this final rule. For example, a cystectomy with continent diversion, code 51596, had a value in the proposed rule that was higher than that for liver transplant. The value for this procedure, which is recognized as complex, has nonetheless been reduced because it appears to be out of line with other services on the fee schedule. Not all of the changes recommended by the CMDs, however, resulted in a lowering of values. For example, cystourethroscopy, code 52000, was increased in value to be consistent with other endoscopic procedures. Finally, adjustments to a series of codes in the transurethral surgery section, 52204 through 52338, were made by removing the RVUS for follow-up office visits that had been built into the values for these procedures. This reduction was made so that the values for these codes would be consistent with other endoscopic procedures on the list whose values do not include follow-up office visits.

[Female Genital System and Maternity Care and Delivery—Codes 56000 Through 59899]

Comment: We received numerous comments from gynecologic oncologists who expressed concern that the work values for complex cancer surgery appeared to be undervalued. We also received comments from obstetricians objecting to the proposed values for maternity care services that they believe are so undervalued that access to care would be affected if they were retained in the final rule.

Response: We reviewed the work values for the codes in this section with the CMDs who agreed that the values for selected gynecologic procedures were undervalued relative to other services on the fee schedule. For example, the codes for hysterectomy in the range 58150 through 58285 were all increased in value.

For the maternity care services, in particular, codes 59400 and 59510, the CMDs accepted the argument that the values for these codes should reflect the

full work required by the multiple visits that must take place during the prenatal period. Consequently, we have increased the values in this final rule for these services.

[Nervous System—Codes 61000 Through 64999]

Comment: We received comments from individual neurosurgeons and specialty societies expressing concern about the possibility of "compression", which they believe may have caused complex neurosurgical procedures to be undervalued in a systematic way.

Response: We reviewed the neurosurgical procedures with the CMDs who noted that there are a number of codes in the neurosurgical section that describe procedures that are infrequently performed, but that are highly complex. There are procedure codes in this section whose work values exceed those of all other services on the fee schedule. However, there are other services that are comparable to those that are valued very high, yet their values are in some cases 30 to 40 percent lower. We intend to further consider in the coming year whether the values for the most complex neurosurgical procedures are correct. For those codes with work RVUs of 42 and higher, we have decided to have payment made on a "by report" basis, because we are concerned that the values that have been established for these services may not be correct. We intend to have our carrier medical staff make individual payment determinations and collect and forward to us for our review the claims they receive for these services. We will use this information, along with advice we receive from the CMDs, individual physicians, and affected specialty societies, in developing final values for these codes.

The work of the CMDs in the neurosurgical section was devoted primarily to providing recommended values for codes that were not surveyed by Harvard. Other changes in this final rule from the values published in the proposed rule were made following the addition of pre- and post-work to a large number of "starred" procedures in this section.

[Eye and Ocular Adnexa—Codes 65091 Through 68899]

Comment: We received numerous comments from ophthalmologists and their specialty societies regarding the physician fee schedule. In general, comments on the work values were limited to their concern about "starred" procedures and retinal and oculoplastic surgery. Some commenters have

questioned why there were some ophthalmology codes omitted from the proposed rule, and suggested that their absence could influence other values. Some commenters asked that the special ophthalmology visit codes be eliminated, but that we create a code for refraction since refraction is not covered by Medicare. We also received a comment that the values for similar forms of cataract surgery appeared to be separated by too large a range of values. Although we did not receive extensive comments on the work values of specific ophthalmology procedure codes from ophthalmologists themselves, we did receive numerous comments from other specialties who expressed concern that, relative to their work, the ophthalmology services seemed to be overvalued.

Response: We have increased the values for "starred" procedures in the ophthalmology section by adding pre- and post-work to selected codes. This issue is addressed in more detail elsewhere in this preamble. In response to the concerns of non-ophthalmologists that the values of cataract procedures appear to be overvalued relative to the procedures they perform, the CMDs undertook a systematic review of these procedures. They began this review by first determining the location of cataract procedures on the common scale. The following is a listing of codes to which they referred and their values. These values are on the Harvard scale, rather than on the fee schedule scale. However, the numbers are being presented here simply to illustrate the relationship of cataract procedures to other procedures on the fee schedule. Code 19162, mastectomy, has a Harvard value of 985. Code 32100, thoracotomy, has a value of 1,000. Code 47600, cholecystectomy, has a value of 917. Code 61750, stereotactic biopsy of an intra-cranial lesion, has a value of 995. Code 66984, extra-capsular cataract removal with intra ocular lens, has a value of 1,019. Based on their clinical experience, the CMDs suggested that the cataract procedures were overvalued.

To determine why the cataracts might be overvalued, they did a more detailed analysis of the components of work: pre-service work, intra-service work, and post-service work. In the Harvard study, intra-service work is a function of time and intensity. The intra-service time for mastectomy is 111 minutes; for thoracotomy, 93 minutes; for stereotactic biopsy, 64 minutes; and for extra-capsular cataract extraction, 54 minutes. The CMDs believe that the time value for this cataract procedure was too high. Further analysis revealed that the intensity for this service may be

overestimated. The following are intensity values for selected services that were surveyed in the Harvard study. Code 33512, coronary artery bypass graft, has an intensity of 7.2. Code 61518, craniectomy, has an intensity of 7.5. Code 66850, phacofragmentation of a cataract, has an intensity of 13.2. Code 66984, extra-capsular cataract extraction with intra-ocular lens, has an intensity of 11.9. The evidence indicated that the ophthalmology services may be systematically overvalued because the intensity values for cataract and other procedures in this section are higher than most other services on the fee schedule. We have not undertaken, however, at this point, any systematic revision of the ophthalmology services because we are unable to resolve this issue in time for this final rule. We believe further consideration of this issue should occur during the coming year and we welcome comments concerning these issues from interested clinicians and specialty societies.

While we have not undertaken a systematic review at this time, we have made minor revisions to the values for cataract surgery. We noted that two procedures, intra-capsular cataract extraction with intra-ocular lens (66983) and extra-capsular cataract extraction with intra-ocular lens (66984), have significantly different values in the Harvard data for post-operative work. We took an average of the post-operative work for both of these procedures and applied it to both of them in this final rule. This resulted in a reduction in value for 66984 and a slight increase in value for 66983.

Regarding retinal procedures, a restudy of ophthalmology was done by Harvard during Phase II without HCFA funding. The report for the retina subspecialty was completed at a much later date than Harvard's Phase II report to us, which formed the basis for the proposed rule values.

In its more recent work, Harvard results from this subspecialty were merged onto the common scale by linking it to general ophthalmology, which, in turn, had already been linked to the common scale. Although some commenters argued that inclusion of the retinal code values would change the place of ophthalmology services on the common scale, we do not believe the omission of a subspecialty affects the location of the specialty on the common scale. This is based on two pieces of evidence. First, an analysis of residuals for high valued codes did not appear to move the specialty on the common scale. Second, ophthalmology already

has high valued linkages. We recently received from Harvard the values of the retina study and have incorporated those values into this final rule.

Lastly, the CPT has added a new code to the 1992 CPT for reporting the determination of a patient's refractive state. This service is not covered by Medicare and an RVU is not shown in this final rule.

[Auditory System—Code 69000 Through 69979]

Comment: We received few comments on the services in this section of the CPT. One commenter stated that removing a glomus tumor (69552) requires more pre-operative evaluation, longer operative time, and greater risks than the stapes drillout (69661) and that the values should be revised. Other commenters expressed concern about the "starred" procedures.

Response: Our CMDs reviewed and recommended an increased value for 69552. Also, revisions have been made to the values for the "starred" procedures in this section. Those changes are described elsewhere. The CMDs reviewed this section to be sure there were no inconsistencies with other values on the fee schedule. Very few changes were made and where they were made, they were done primarily to make the values consistent with decisions that have been made for other services. For example, 69155, radical excision of an external auditory canal lesion with neck dissection, was reduced in value to be consistent with all other procedures for which a neck dissection is performed. A work value of 3.21 has been added to all procedures involving neck dissection, since the work of a neck dissection is comparable regardless of the primary procedure.

[Pathology—Codes 80002 Through 89399]

Comment: We received numerous comments questioning the RVUs for pathology services. Most of the comments focused on concerns with the linking methodology and statistical analyses performed by the Harvard study team. Several commenters expressed a belief that all the physician pathology RVUs are underestimated in the proposed rule. Some pathologists commented that their waiting time should be included in the calculations of relative work values for pathology services since sometimes waiting time is included for surgeons.

Response: As described earlier in the section on independent studies, we forwarded these comments to the Harvard study team for their review. Based on their comment, and our

concern that changes in linking methodology at this point in time would have significant implications for the entire fee schedule, we have decided not to make an across-the-board adjustment to the pathology values. For selected codes, however, we did receive a recommendation for an increase in values from Harvard, and we have increased those values in this final rule. The codes affected are: 85060, peripheral blood smear interpretation; 85097, bone marrow smear interpretation; and, 88309, the Level VI surgical pathology code. The CMDs reviewed the values of all the pathology services. An area of particular attention was the surgical pathology codes. No changes from the Harvard values were recommended by the CMDs who noted that the codes will be used to report services on a per specimen basis. Although surgeons may have included waiting time in their measurement of work for surgical services, Harvard chose not to explicitly include it in the measurement of work for pathology services because pathologists can perform other services while waiting for specimens. We concur with this policy and are not adjusting pathology work estimates based on this comment.

[Transplant Surgery—Codes 33935, 33945, 47135, 50360, and 50365]

Comment: Based upon the results of an independently funded study, a number of commenters questioned the relative work values for a large number of CPT codes that are performed by transplant surgeons and stated that the "fitness to rate" issue made the validity of the Harvard RVUs questionable. Commenters also asked that we value the physician work in organ acquisition (codes 33930, 33940, 47133, 50300, 50320) in the same way that we value physicians' work for the transplant, rather than continuing to freeze payments for this activity. They indicated that they recognize that we pay for organ acquisition through payments to hospitals. They believe, however, physician work for this service should be valued consistent with that for other physician services. Other commenters raised a face validity issue regarding renal transplant with and without nephrectomy in that the value of the procedure for renal transplant without nephrectomy was higher than the value for renal transplant with nephrectomy. These commenters also indicated that under the global fee definition for surgical services, we should include the RVUs for physician work in managing immunosuppressive therapy in the RVUs for the transplant. They stated that this work significantly

increases the total work during the post operative period and is unique to transplants.

Response: As noted in the discussion of the special studies in the previous section, we are not confident that the values for heart and liver transplants are correct. We, therefore, have decided to have claims for these services paid for on a "by report" basis because of the high level of variability of these services and the low frequencies paid by Medicare. We believe payment for these services during the first year of the fee schedule is best established on a claim-by-claim basis. We plan to establish work RVUs in the 1993 fee schedule.

We have not included any RVUs for organ acquisition codes in the fee schedule. Physician services for organ acquisition are paid to hospitals as permitted by section 1881 of the Act. These payments were excluded from reasonable charge payment and will also be excluded from the fee schedule. Costs for these services are considered to be hospital costs, and therefore, we are not valuing the services as physicians' services.

We have resolved the face validity issue regarding renal transplant with and without nephrectomy by decreasing the value for renal transplant without nephrectomy slightly and setting the value for renal transplant with nephrectomy at a higher level.

We acknowledge that the physician work in managing the post-operative immunosuppressive therapy for transplant patients presents an added dimension to the post-operative work that is not found following other surgeries. In addition, we understand that the physician who performs the surgery may or may not manage the patient's post-operative immunosuppressive therapy because different medical centers and transplant teams have different practices. The values we show in this final rule for renal transplants do not include RVUs for managing immunosuppressive therapy. We will pay separately, however, for the visits furnished by a physician for immunosuppressive therapy following a transplant, whether the therapy is managed by the surgeon or another physician. As indicated in our discussion of global surgical payments, we have created a modifier to be used when a physician bills for visits that are not included in the global fee. The global payment for the surgery, however, will include only RVUs for the post-operative surgical care and will not include any RVUs for post-surgical immunosuppression therapy.

[Chiropractic Manipulation—Code A2000]

Comment: Commenters objected to the RVU for chiropractic manipulation because they believe that the service was undervalued relative to osteopathic manipulation. They recommended that the value be increased.

Response: The CMDs discussed this issue at length. They recommended and we agree that the charge based RVU that was shown in the proposed rule should be increased. While they did not agree with the commenters that this service was identical to osteopathic manipulation, they did agree that it was sufficiently comparable to warrant an increase to a level slightly below that of a brief osteopathic manipulation.

[Osteopathic Manipulation—Codes M0702 Through M0730]

Comment: The comments we received on these services focused on the fact that we did not show RVUs for all of the codes in the proposed rule.

Response: The CMDs recommended RVUs for those codes that had not been surveyed by Harvard.

2. Unlisted Procedures, Local Codes, and Carrier Priced Services

We proposed to permit carriers to individually value services billed for unlisted procedures for which we did not have relative values from Harvard, after review of pertinent medical information that describes the services furnished.

Under the proposed rule, until a national code had been established, new procedures for which there is no national code would be assigned a local code and would be paid under the fee schedule using relative values determined by the carriers.

We proposed to minimize the use of local codes by requiring that carriers acquire prior approval from us for the use of local codes; by annually reviewing all local codes to identify those that should be moved to the national coding system; and by establishing national HCPCS codes for new services deemed not appropriate for inclusion in the CPT.

[Use of Local Codes]

Comment: Commenters believe carriers should be able to continue to use local codes if they choose and should have the autonomy to price them individually. They object to the restriction on use of local codes to services with prior HCFA Central Office approval, because they believe that standardization of coding would reduce payment for many services paid

previously under local codes tailored to their specific services and needs.

Response: We do not agree that carriers should continue to have the autonomy to set local codes and prices for services if they choose not to use the physician fee schedule. The law requires us to establish a national fee schedule for physicians' services. While we acknowledge that it is not practical for us to establish national payment amounts for each service that Medicare may cover, we believe we are responsible under the law for carefully monitoring and limiting the circumstances in which payment is made for physicians' services under local codes or under carrier pricing. This is necessary so that we can create national payment amounts for these services as the volume and the nature of the service warrants and to ensure that the payment for services is made under the fee schedule as required by law.

[Payment Amounts for Local Codes]

Comment: Commenters stated that while carriers should have the latitude to pay for procedures billed under local codes and unlisted codes, and for new procedures, the payment amounts should be developed with input from local physician organizations. When RVUs for procedures are reviewed at the national level, they should be available for public comment.

Response: We intend to closely monitor payments made by carriers for physician services for which we have not provided national payment amounts in the fee schedule. We intend to tightly control the use of local codes by carriers by requiring carriers to obtain prior approval from HCFA Central Office before making payments for new local codes. We believe this policy will both minimize use of local codes and give us early warning of new services for which we should develop national codes and payment amounts. In addition, we will closely monitor payments made under the unlisted codes to ensure that their use is minimal.

Carriers typically consult with specialists and specialty organizations as needed to determine payments for unlisted services and to establish payments for local codes. We expect the payment amounts established by carriers for these services to be replaced when service volume warrants it by national payment amounts that would be subjected to comments as interim values. In view of the closeness with which we intend to control carrier payment for local codes and to monitor use of unlisted codes, we do not believe it is necessary to establish a more formal process at the local level. This

requirement could unnecessarily delay payment of claims for these services.

3. RVUs for Limited Licensed Practitioner Services

Harvard studies have provided many physician work RVUs for limited licensed practitioner services that are the same as those furnished by an MD or a DO. Many of the same codes are used by both limited licensed physicians and MDs and DOs. As stated earlier, section 1848(c)(6) of the Act prohibits the Secretary from imposing different RVUs or a different CF for a physician's service based solely on the specialty of the physician. Thus insofar as the services furnished by limited licensed practitioners are the same as those furnished by MDs and DOs, we are required by law to provide the same payment amounts for those services. In the proposed rule, we requested public comments on whether the services of these practitioners are substantially different from the identically coded services of MDs and DOs.

[Same Payments for MDs and Limited Licensed Practitioners]

Comment: Some commenters believe limited licensed practitioners (that is, optometrists, podiatrists, chiropractors, oral surgeons, and dentists) should not be paid the same as MDs, because they do not furnish the same services to their patients, even when they use the same code to bill for the service. These commenters argued that MDs and DOs have received training and have a range of skills and abilities that enable them to diagnose and treat conditions that require knowledge of the interrelationship of all body systems. They stated that limited licensed practitioners are trained to diagnose and treat conditions only within a limited scope. They stated that non-MDs have lower training costs, lower practice expenses, and lower malpractice costs than MDs. Other commenters stated that limited licensed practitioners should be paid identically to physicians for a service billed under the same code because the services are identical and the law prohibits us from having a specialty differential under the fee schedule.

Response: Section 1861(r) of the Act defines the limited licensed practitioners listed above as physicians under Medicare for covered services that are within the scope of their licenses. Section 1848(c)(6) of the Act prohibits fee schedule payments from varying by physician specialty. For procedure codes that are used by both MDs and limited licensed practitioners, we will pay the

same amounts. We recognize, however, that there are some services that are done virtually only by the limited licensed specialties (for example, chiropractic manipulation; HCPCS code A2000), and we have kept codes for these services and have created RVUs for them. We will consider different payment levels for services furnished by both MDs and DOs and limited licensed practitioners if we are provided convincing evidence that the services are materially different depending on the type of practitioner furnishing the service. So far, we have not received this evidence.

4. Radiology Services

a. *Integration of existing radiologist fee schedule into the physician fee schedule.* In establishing the physician fee schedule, the language of Public Law 101-239 acknowledges that special rules are already in effect with respect to payment for radiology services. The radiologist fee schedule presently applies to radiology services furnished by or under the supervision of a physician certified or eligible to be certified by the American Board of Radiologists or by a physician for whom radiology services account for at least 50 percent of the total amount of charges made under Medicare Part B. The radiologist fee schedule values are based on an RVS developed by the ACR, which we have adopted.

Section 1848(b)(2)(A) of the Act specifies that the relationships among values established in the existing fee schedule must be preserved, while making appropriate modifications to ensure that RVUs are consistent with those for other physician services. The proposed rule set forth a methodology for rescaling current RVUs for radiology services under the statutory requirement.

[Method for Integrating Radiologist Fee Schedule]

Comment: Some commenters stated that our methodology for integrating the radiologist fee schedule into the physician fee schedule was inappropriate because it does not account for CF payment reductions already experienced by radiologists totaling 18 percent in 1989, 1990, and 1991. These commenters believe that the radiologist fee schedule RVUs do not reflect statutorily mandated reductions to the 1989 through 1991 CFs and should not be linked with the RVUs developed by Harvard. Rather these commenters believe the 1991 radiologist fee schedule CFs reflect the 1989 through 1991 payment reductions and should be used to integrate the radiologist fee schedule.

Response: The work RVUs and the practice and malpractice expense RVUs were rescaled using different methodologies. The work RVU was rescaled based on the relationship between the work portion of the radiologist fee schedule RVU and the work RVUs developed by Harvard. For the work RVUs, the level of payment (the CF) was not relevant to the rescaling. Rather, maintaining the relative relationship between radiology services and placing the RVUs on the Harvard scale was the essential task. We believe this is a valid methodology because it recognizes that the RVUs—not the radiologist fee schedule CFs—are the basis for determining the appropriate relative relationship between physician work for different services.

RVUs from the Harvard study indicated that the work portion of radiologist fee schedule RVUs was significantly overvalued relative to the RVUs for other services, even after accounting for prior payment reductions. Therefore, our methodology for determining the work RVU on the Harvard Scale had the effect of reducing payment for radiologist services.

With regard to the practice expense and malpractice RVUs, our methodology is consistent with the way we computed these RVUs for other services. The practice expense and malpractice RVUs are based on 1991 average allowed charges (or in the case of radiologist services, the 1991 national average CFs) as specified by statute. (For a more detailed explanation of how payment reductions affect the practice expense and malpractice RVUs, see the preamble section on charge-based computation of practice expense and malpractice RVUs.)

[Use of Weighted Mean for Adjustment]

Comment: Some commenters believe that the adjustment factor for integrating the radiologist fee schedule work RVUs should be determined by using a weighted mean for each service surveyed by Harvard. These commenters also stated that if we use either the mean or median ratio method that the median ratio method would be preferable as it would be unaffected by outlier values. Other commenters supported our use of the mean ratio method because the median ratio method has the "defect of being insensitive to how near or far from the central tendency are the ratios not exactly at the mean."

Response: For this final rule, we rescaled the radiology work RVUs using an adjustment factor based on the mean ratio method. We believe this

methodology, where each service has equal weight in determining the adjustment factor is a fair way to integrate the radiologist fee schedule relative values into the overall RVS because a weighted approach gives disproportionate weight to services with high values or high volume. We also considered using an adjustment factor based on a median ratio method. We believe this scaling method is equally valid. Since one does not seem clearly preferable to the other and since we received comments supporting the use of the unweighted mean, we decided to retain that method for this final rule.

[Magnitude of Reduction Required by Public Law 101-508]

Comment: Some commenters stated that Public Law 101-508 and the accompanying committee reports prescribe a cumulative 13 percent reduction in the national average radiology CF to eliminate radiology overpricing. According to these commenters, radiology should receive only a 4 percent reduction under the proposed rule methodology, as Public Law 101-508 already mandated reductions in radiology CFs of 9 percent. These commenters recommend an alternative to our rescaling methodology, which consists of the following steps:

- Reduce the 1991 national average radiology CF of \$12.80 by 13 percent to \$11.136;
- Divide \$11.136 by the physician fee schedule CF (proposed at \$26.873); and
- Multiply each radiologist fee schedule value by the quotient produced by the above step.

According to these commenters, the above computations would result in RVUs for radiology services that are on the same scale as other physician services and would reduce payments for radiology services by the intended 13 percent from the 1990 average.

Response: We do not believe the law specifies the magnitude of the payment reductions for radiologist services under the physician fee schedule. Public Law 101-508 required the Secretary to determine a national average radiology fee schedule CF and reduce it by 13 percent with a maximum reduction of 9.5 percent in any locality. The above commenters believe, because the maximum reduction in 1991 was 9.5 percent, Congress intended for radiologist services to receive only an additional 4 percent payment reduction in 1992.

We disagree. There is no indication in that Congress prescribed the level of the reduction as suggested by the

commenters. The Senate Finance Committee Report (136 *Cong. Rec.* S.15645 (daily ed. Oct. 18, 1990)) states that HCFA and PPRC estimated that radiology services were overvalued by 15 percent. The report also states that "this should not be construed as a final judgement on this issue. Rather, it is a working assumption, which will be adjusted as additional information becomes available in the future." Since the time of this report, additional information has become available, which reveals that the work portion of the radiologist fee schedule remains significantly overvalued. Furthermore, section 1848(b)(2)(A) requires the Secretary to base the RVUs for radiologist services on the current fee schedule with appropriate modifications to assure that RVUs for radiologist services that are similar or related to other physicians' services are consistent with the RVUs established for those similar or related services. We believe this language requires us to maintain the same relative relationships that exist currently among radiology services while establishing the appropriate relative relationships with other physician services. As we stated above, we believe this requires us to rescale the work, practice expense, and malpractice RVUs separately.

We do not believe the appropriate relative relationships for work, practice expense, and malpractice can be established by rescaling the entire RVU as suggested by these commenters. We believe the Harvard study should be the basis for establishing consistency between work RVUs for radiology and other physician services. We believe our methodology is consistent with the requirements specified in section 1848(b)(2)(A) of the Act.

[Use of Subset of Phase III Values to Integrate Radiology]

Comment: Some commenters objected to the services that we used to determine the rescaling factor. According to these commenters, the 14 cross-specialty links used by Harvard to develop values for the surveyed procedures are inadequate. These commenters propose that we base the adjustment factor on a set of 13 services for which Harvard "obtained magnitude estimates from non-radiology specialties."

Response: We are rejecting this comment, because we do not believe the values for the 13 services being recommended by these commenters are any better than the values that were used in the rescaling process. We believe the cross-linking process should include all of the services valued by

Harvard, rather than arbitrarily choosing among the different services studied. For radiology, this would include all 65 services studied by Harvard. Finally, Harvard reviewed these comments on links for radiology and Harvard continues to support its original links.

b. *General diagnostic radiology.* The proposed rule did not contain any specific proposals regarding general diagnostic radiology apart from the proposal on rescaling values and integrating the radiologist fee schedule into the fee schedule for physicians' services. The following is a discussion of comments received that are not directly related to any particular subspecialty of radiology.

[Inclusion of the Technical Component of Radiology Services]

Comment: Several commenters noted that the PPRC had asserted that the technical component of radiology services was not supposed to be a part of physician payment reform; that is, Medicare program cuts that began with the radiologist fee schedule in 1989.

Response: We disagree. Section 1834(b) of the Act, which mandated the radiologist fee schedule applies to services of physicians and suppliers, clearly indicates that it applies both to technical and professional components of these services. Section 1848 of the Act specifically includes in the definition of "physicians' services" for purposes of the physician fee schedule, services under sections 1861(s)(3) (the basis for coverage of the technical component of diagnostic x-ray services) and 1861(s)(4) (the basis for coverage of the technical component of therapeutic radiology services).

[Classification of Radiology Services]

Comment: Several commenters noted that some procedures classified as radiology services, that is, the procedures in the 70000 series of the CPT, are generally furnished by physicians other than radiologists. However, the physicians' fee schedule RVUs for these procedures are derived from the relationships these procedures had to other radiology procedures under the radiologist fee schedule without input from the experience of other specialists in furnishing the procedures. An example given is transrectal prostatic ultrasound, which urologists maintain they commonly perform in their offices with no involvement by a radiologist.

Response: As was noted above, section 1848(b)(2)(A) of the Act requires the Secretary to base RVUs for radiology services under the overall

physician fee schedule on the existing radiologist fee schedule with appropriate modification to link the RVUs to the Harvard scale. Therefore, in order to satisfy this statutory requirement, we maintained the radiologist fee schedule relationships for these procedures in the initial implementation of the physicians' fee schedule. However, section 1848(c)(2)(B)(i) of the Act requires the Secretary to review the RVUs for physicians' services at least every 5 years, and evidence could be presented upon which we could base a revision of the fee schedule RVUs for a particular procedure.

[Inadequate Payments Due to Low Volume]

Comment: A few commenters, physicians in general practice who stated that they do a small number of radiological procedures in their offices, believe that the payment levels would not enable them to meet the expenses of maintaining radiologic equipment in their offices.

Response: We believe that a special payment system for low-volume entities would be both complex to administer and inappropriate for widely available x-ray procedures. In addition, it would not be consistent with a resource-based RVS payment system.

[Payment Cuts for Radiological Residency Programs]

Comment: Several commenters involved with radiological residency programs indicated that the cut in payments would decrease the quality of residency training programs, emergency coverage of radiological services, the quality of the examinations, medical research activities, and the ability of hospitals to furnish services to indigent patients. One commenter suggested that radiologists and radiation therapists in teaching hospitals be exempt from the reductions under the physician fee schedule in order to retain the high quality of training in academic centers.

Response: It is our responsibility to pay for physicians' services for Medicare beneficiaries in accordance with section 1848 of the Act. We do not believe Congress intended for us to establish different payment amounts for teaching hospitals. As for graduate medical education programs, we believe Medicare makes sufficient payments in support of these programs through direct medical education payments for training furnished both in hospitals and freestanding settings; indirect medical education payments for training furnished in hospitals; and attending

physician billings. Further, we have no reason to believe radiology is different from any other specialty in this respect.

[Payment for Self-Referred Imaging Centers]

Comment: Several commenters suggested that as a means of reducing waste and overuse of radiology services, the Medicare program should prohibit physicians from referring patients to imaging centers in which they have investments as well as prohibit payment for x-rays performed in the physician's office on the physician's referral. One commenter suggested that legislation should be enacted to prevent an individual physician from being paid for imaging procedures he or she prescribes.

Response: These matters are beyond the scope of this rule, although carriers should deny payments for diagnostic services they determine are not medically necessary. Referral issues are appropriately addressed through regulations promulgated by the OIG. A relevant final rule entitled, "Medicare and State Health Care Programs: Fraud and Abuse; OIG Anti-Kickback Provisions: Rule" was published in the *Federal Register* on July 28, 1991 (56 FR 35952).

[Quality of Non-Radiologist X-Rays]

Comment: Some commenters indicated that x-rays furnished by physicians other than radiologists are inferior in quality and should be paid either at a lower amount or not at all. In related comments, it was suggested that we should ensure that radiological and ultrasonic diagnostic procedures are performed on quality equipment before making payments.

Response: Generally, Medicare pays for a physician's service if the service is covered by Medicare and the physician is licensed in the State in which the service is performed. However, in establishing the screening mammography benefit, Congress did establish criteria to ensure that the physician performing the service had special qualifications. At this time, Congress has not chosen to establish special criteria for other radiological services. Further, we are specifically precluded by section 1848 of the Act from paying a differential based on the specialty of the physician.

As far as the quality of the x-ray is concerned, if we, or the carrier, learn that inferior images are being taken because of poor quality equipment or training, or for other reasons, there would be a basis to deny payment on the grounds that it did not serve a medically necessary purpose.

[Bundling of X-Ray Services]

Comment: One commenter suggested that payments for x-rays performed by internists, orthopedists, or other nonradiologist physicians should be included in the visit or consultation payment in the same way that EKGs have been.

Response: Section 4109 of Public Law 101-508 precludes separate payment for the interpretation of EKGs. This provision has no effect on payments for other procedures. Congress specifically limited this provision to EKGs.

[Billing of Professional/Technical Components]

Comment: One commenter requested clarification as to whether it will be necessary to bill professional and technical components of radiological services separately. The commenter believes that it would be easier and less costly to report the combined amount with a modifier on a single line of the claim to keep reporting consistent with billing for other insurers.

Response: Billing instructions will be issued shortly after the publication of this final rule.

[Fee Reductions and Outpatient Radiology Payments]

Comment: Several commenters suggested that the fee reductions imposed on radiology should not be used in determining payments to hospitals for outpatient radiology services. One commenter questioned whether the professional and technical component apportionment set forth in the statute to compute the blended rate element of the cost limit provision is relevant under the new physician fee schedule. The commenters believe that it is time to re-evaluate the payment methodology used to pay hospitals for the technical component of outpatient radiology services and that technical component payments should be separated from the fee schedule and paid to the hospital on a cost basis.

Response: Payments under the statutory provision for hospital outpatient radiology and other diagnostic services are outside the scope of this rule. Under section 1833(n)(1)(B)(i)(II) of the Act, fee schedule amounts for radiology services furnished in participating physicians' offices in the locality are a factor in determining payments to hospitals for outpatient radiology services. Carriers will notify intermediaries of the fee schedule amounts for individual services in the locality so that this limit can be applied.

[High Cost of Technical Equipment]

Comment: Several commenters indicated that we should address the extremely high cost of equipment used to furnish radiological services.

Response: We have no authority to interfere with prices manufacturers charge for their products.

c. *Computerized Axial Tomography (CAT) and Magnetic Resonance Imaging (MRI) procedures.* The proposed rule did not contain any specific proposals on payments for CAT or MRI procedures other than to implement the requirement of section 1834(b)(4)(E) of the Act that, effective for services furnished after December 31, 1990, the amount otherwise payable for the technical components of these procedures will be reduced by 10 percent.

[Payment Cuts and the Provision of CAT and MRI]

Comment: Several commenters indicated that cuts in payment levels for computerized axial tomography (CAT) and magnetic resonance imaging (MRI) procedures will make furnishing these services difficult. Commenters cited both the high acquisition costs and annual maintenance costs of this equipment. One commenter noted that these types of high technology would have never been developed in the limited market that these payment reductions would produce. Several commenters indicated that there have been significant reductions in payments for CATs and MRIs under the radiologist fee schedule, that we did not publish a final rule on the radiologist fee schedule addressing their comments on these reductions, and that payment amounts for the technical components of these procedures under the physician fee schedule will be below costs for many freestanding facilities. Some commenters noted that some imaging centers have binding contractual arrangements with physicians to interpret CATs and MRIs and that the centers will bear the brunt of payment reductions. It was suggested that technical component RVUs for these procedures be modified to ensure that imaging centers have sufficient funds to absorb these losses. Some commenters cited the 10 percent reduction to payments made under the radiologist fee schedule for the technical components of CATs and MRIs imposed by section 4102(d) of Public Law 101-508.

Response: We do not believe it would be appropriate to increase technical component RVUs in order to enable imaging centers to meet their contractual obligations to physicians; it

may be necessary for some centers to seek to renegotiate the arrangements they have with physicians. It is true that the reductions that applied to radiology services generally also applied to the technical component payment for CATs and MRIs, and these reductions would have applied whether or not a final rule had been published on the radiologist fee schedule. The proposed rule was not specific as to whether the 10 percent reduction continues in effect under the fee schedule for physicians' services. Since section 4102(d) of Public Law 101-508 did not specify a date upon which this reduction will end and, thus, the section is by its own terms, still applicable, and since the technical component is based on average allowed charges in 1991, we have decided that the 10 percent reduction will be taken into account in setting the technical component RVUs for MRIs and CATs. As we discussed in the proposed rule (56 FR 25840), we plan to gather the needed cost data to revise technical component payments under the fee schedule over time.

[Competition Among Hospitals]

Comment: One commenter indicated that Medicare physician payment reform does nothing to address the problem of wasteful competition among hospitals in terms of spending on CAT, MRI, and nuclear medicine imaging equipment.

Response: We agree. However, we believe that the problem of unnecessary duplication of high technology equipment in hospitals is being addressed through our final rule on a prospective payment system for inpatient hospital capital-related costs that was published on August 30, 1991 (56 FR 43358). Under the revised payment system, which became effective October 1, 1991, hospitals will have more incentive to bring their capital-related costs under control.

[Impact of CAT/MRI on Cost]

Comment: Some commenters suggested that furnishing CATs, MRIs, and nuclear medicine diagnostic procedures may have a positive effect on health care costs by making some invasive procedures requiring a hospital stay unnecessary.

Response: There is no doubt that these types of highly sophisticated diagnostic equipment have made some exploratory surgeries unnecessary. However, our obligation is to pay an appropriate fee for a service that is based on the relative resources required to produce it.

d. *Portable x-ray.* Services of portable x-ray suppliers consist of 3 components: Professional, technical, and

transportation (that is, transporting equipment to a beneficiary).

In the interim final rule implementing the fee schedule for radiologist services that was published on March 2, 1989 (54 FR 8999), we instructed carriers to establish CFs for the services of portable x-ray suppliers separate from the CFs applicable to the services of all other entities. As described earlier, section 1848(c)(6) of the Act precludes the recognition of specialty differentials under the fee schedule. Therefore, we proposed in the June 5 physician fee schedule proposed rule that all three components of the services of portable x-ray suppliers be paid under the fee schedule for physicians' services using the same CF as applies to all other services payable under that fee schedule. We invited comments on how to standardize the billing and RVUs assigned to the transportation component.

[Inclusion of Portable X-Rays]

Comment: A national organization that represents the interests of portable x-ray suppliers indicated that the legislative history of the definition of "physicians' services" suggests that portable x-rays should be excluded from the fee schedule for physicians' services. It was noted that the definition of "physicians' services" included x-rays that are "commonly performed or furnished by a physician or in a physician's office," and that portable x-ray services are never performed "by a physician or in a physician's office." In addition, the commenter noted that the purposes of physician payment reform, such as the assigning of a relative value regardless of physician specialty, the establishing of the MVPS, limitations on balance billings, and research and dissemination of information on outcomes do not support the inclusion of portable x-rays within the scope of the fee schedule.

Response: The commenter has used the definition of "physicians' services" established for purposes of the MVPS in section 1848(f)(5)(A) of the Act out of context. The definition of "physicians' services" payable under the fee schedule includes services covered under section 1861(s)(3) of the Act, which includes, in pertinent part, " * * * diagnostic x-ray tests (including tests under the supervision of a physician, furnished in a place of residence used as the patient's home, * * *)" (see sections 1848 (a)(1) and (j)(3) of the Act). While it is true that the technical component of services of portable x-ray suppliers are not "physicians' services" as that term has traditionally been used in the Medicare program, there is no question

that these procedures are included in the definition of that term that Congress established for purposes of the fee schedule for physicians' services.

[Financial Disincentives]

Comment: A commenter noted that inclusion of the services of portable x-ray suppliers in the fee schedule is inconsistent with other HCFA Medicare goals such as access to care for beneficiaries requiring complex care in NFs, access to care in HPSAs and other rural locations, and cost control. The commenter went on to indicate that the inclusion of these services in the fee schedule creates powerful financial disincentives for portable x-ray suppliers to remain in business. Portable x-ray suppliers in rural areas would be the most likely to close because the long distances make the costs of doing business especially high, and NF patients generally would be denied access to x-ray services. These consequences would result in increased costs to the Medicare program because it would be necessary to transport NF patients by ambulance to receive the x-ray services they need at three or four times the costs of these services if furnished by portable x-ray suppliers.

Response: We do not believe that the inclusion of services of portable x-ray suppliers will result in these dire consequences. Moreover, Congress specifically provided for the inclusion under the fee schedule of services now under the radiology fee schedule. Nevertheless, we will monitor for any significant changes in access.

[Relationship of Portable X-Ray to HHS and Congressional Actions]

Comment: Some commenters noted that inclusion of the services of portable x-ray suppliers in the fee schedule would undo actions undertaken by both HHS and Congress in recent years to recognize the special circumstances of the services furnished by these suppliers. These special actions include the decision by HHS to establish a separate CF for portable x-ray services under the radiologist fee schedule, the Congressional decision to exclude portable x-ray services from the reductions generally applicable to radiology services, and the recognition by HHS of historical errors caused by subjecting services of portable x-ray suppliers to the physicians' fee freeze of 1984 through 1986 and "commingling" portable x-ray and physicians' charges in prevailing charge profiles.

Response: We believe the law requires that we pay for the services of portable x-ray suppliers under the

physicians' fee schedule. The special treatment for portable x-ray under the radiologist fee schedule was made under the radiologist fee schedule statutory authority that allowed us to make payment distinctions based on specialty. (We considered portable x-ray to be a specialty for this purpose.) This authority does not exist under the physicians' fee schedule. In addition, the statutory exemptions of portable x-ray services from the reductions that applied to other radiologist fee schedule services (section 6105(a) of Public Law 101-239 and section 4102(a) of Public Law 101-508) were effective for radiologist fee schedule years 1990 and 1991, respectively. To preserve payment distinctions for similar services under the physicians' fee schedule would be inconsistent with the prohibition against recognition of specialties under the new fee schedule. Our response to the next comment sets forth our proposal for paying separately for the types of services portable x-ray suppliers furnish that other x-ray suppliers do not.

The commenters' reference to the recalculation of "commingled" and "frozen" prevailing charges are longstanding reasonable charge issues that predated both fee schedules and are beyond the scope of this final rule. We recognized that there were some problems and instructed the carriers, under the supervision of the HCFA regional offices, to recompute the radiologist fee schedule CFs for 1991 if these problems existed. We believe that the existence of these types of problems and the sometimes inexplicable payment differences that resulted under the reasonable charge system are clear indications of the benefits of discarding that system altogether in favor of a national fee schedule.

[CF for All Three Components]

Comment: Several commenters objected to the proposal that all three components of portable x-ray services be paid using the same CF applicable to all other services payable under the fee schedule. Several commenters suggested that there should be a payment distinction between an x-ray procedure furnished by a portable x-ray supplier and one furnished by a stationary facility. Some noted that many of the patients in NFs who require portable x-ray services are senile, uncooperative, and incontinent, among other conditions, and are at risk of sustaining orthopedic injury during handling. Some commenters indicated that the technical component services furnished by the two types of entities are so different that they suggested that a series of distinct codes could be used to distinguish

procedures furnished by portable x-ray suppliers. Other commenters suggested that the current procedure codes be retained, but that the differences between the portable service and the nonportable service can be described with separate codes for a set-up service (or long-term care differential), the transportation component, and an additional payment of \$30 for "after hours" services. One commenter suggested that the RVUs established for the set-up service be locality-specific because of wide variations in current payment levels for portable x-ray services. One commenter suggested the establishment of two set-up codes: one for institutional visits with an RVU of 1.5 and another for home visits with an RVU of 2.0, reflecting the increased difficulty of carrying the equipment into a private home.

Response: We have considered the comments of representatives of the portable x-ray industry concerning the difference between the technical component of x-ray services furnished by portable x-ray suppliers and other entities, and it is our position that the difference is in the preparation of the patient for the x-ray procedure and the transportation of the radiological technician and equipment to the site in which the x-ray is taken, for example, NF and private home. It may be the case that, if NF patients are severely debilitated, it is medically appropriate to transport them to the hospital to receive the necessary diagnostic services.

As a practical matter, our position in this matter has not significantly changed from that which we discussed in the interim final rule on the radiologist fee schedule (March 2, 1989, 54 FR 8999). That discussion indicated that the technical components of services furnished by portable x-ray suppliers were generally different from those furnished by other radiological entities because of the extra time needed for assembling and dismantling equipment and because elderly patients required extra time for the set-up of the x-ray. Thus, our decision to create a separate CF for portable x-ray was to recognize the additional costs related to the setting up of the x-ray equipment. These distinctions involving payments under standard radiology codes would be inappropriate under the physicians' fee schedule. Rather than establish a whole new set of procedure codes for every service a portable x-ray supplier might furnish, we will use a different methodology for recognizing these additional costs.

We are providing a new payment distinction between procedures furnished by portable x-ray suppliers and other entities that furnish x-ray procedures while paying for the professional component and the technical component of x-ray procedures furnished by all entities (other than hospitals) on the same basis. We have developed a Level 2 HCPCS code that describes the set-up service (placing the patient into position to have the x-ray taken). The new code will be billable for each patient receiving x-ray services from the portable x-ray supplier and will apply during both single-patient and multiple-patient trips. We have established RVUs of .22 for practice expense and .01 for malpractice expense for this code based on the current national payment difference between a group of technical component services most commonly performed by portable x-ray suppliers and the same technical component services furnished by other entities. Since we believe this set-up service is essentially the work of the x-ray technician, we will vary the payment by locality using the practice expense GPCI.

A payment differential for "after hours" services was rejected under the radiologist fee schedule (see the MCM, section 5262.L.). We are continuing this policy under the physicians' fee schedule.

[Transportation Payment Policies]

Comment: Some commenters indicated that our request for suggestions about how to standardize payments for the transportation component of portable x-ray services was inappropriate and that we should have proposed a methodology to which they could respond. We received few suggestions on ways to develop a standardized methodology for determining payments for the transportation of the portable x-ray equipment to the site where the x-ray procedure is performed. It was suggested that payments for the transportation component either be frozen at 1991 locality-specific levels, or that national RVUs of 3.5 be assigned to the HCPCS transportation codes. They suggested RVUs should reflect the time and expense of travelling to a patient's residence, to the developing center, and to a physician's office to have the x-rays interpreted. Several commenters indicated that a standardized approach was not workable.

Response: We have decided to retain the current practice of having the carriers price this service, since there are wide differences in transportation

payment policies among the carriers. These policies are related to urban and rural travel differences, and no uniform policy that takes local conditions into account seems workable. Carriers will continue to establish local RVUs for this service, as was the case under the radiologist fee schedule. In other words, our proposal for the set-up payment is an incremental payment based on the number of patients who receive services, while the transportation component payment is "prorated" over the number of patients who receive services.

[OIG Study]

Comment: At least one commenter suggested that at the time of publication of the proposed rule, the findings of a study of payments for portable x-ray services, mandated by section 6134 of Public Law 101-239 and conducted by the OIG had not been published. The commenter believes that the proposed changes should await the publication of the findings of that study.

Response: We do not agree. No information was identified in that study that materially affects our decisions set forth in this final rule. Nevertheless, the study was forwarded to Congress on October 29, 1991.

[Local Input Into Transportation Costs]

Comment: Some commenters indicated that some States require portable x-ray suppliers to have special equipment, such as large vans with hydraulic lifts, to move their equipment, and there should be local codes to take these considerations into account.

Response: Since transportation costs will continue to be priced by carriers, this issue will be dealt with locally based on carrier knowledge of State requirements.

e. Interventional radiological services. Under the physician fee schedule there is a need to standardize payment policies for interventional radiological services, since differences exist among carriers. We proposed to standardize payment policies as follows:

- Discontinue the use by carriers of the CPT complete procedure codes that describe interventional radiological services.

- Pay for: (1) the radiological aspect of interventional procedures as described by S&I CPT codes, and (2) the primary nonradiological service associated with the procedure, as described by a nonradiological procedure code, such as a surgical code, at the full fee schedule amounts subject to the deductible and coinsurance.

- For any other procedure code associated with the procedure, pay 50

percent of the amount that would be otherwise payable for the first additional procedure, 20 percent for the second, and 10 percent for each additional procedure. We would not reduce payments for any procedure code for which the RVUs already reflect a reduction.

[Separate Billing]

Comment: Nearly all commenters who addressed our proposal to discontinue the use of the CPT complete procedure codes for interventional radiology in favor of separate billing for the radiological and nonradiological aspects of the procedures with reduced payment levels for additional procedures generally approved of the proposal. Most endorsed the activities of the ACR and the Society of Cardiovascular and Interventional Radiology, which are trying to work out the details of the conversion to a new coding system for these procedures, although some commenters indicated that they favored the position of one organization over that of the other and noted that the proposed system would allow for consistency in billing for these procedures regardless of the type of physician involved. The commenters believe that it would not be necessary to have reduced payment levels for additional procedures if the appropriate RVUs were assigned to these procedures, since that action would avoid inevitable differences in carrier interpretations. Some commenters indicated that the proposed limitation on payments for additional procedures performed at the same sitting is usually inappropriate for professional component payments because the efficiencies obtained are related to manipulations of equipment, schedules, and rooms, while the physician still has more images to interpret.

Response: We are adopting our proposal to discontinue the use of complete procedure codes for interventional radiology procedures in favor of separate billings for the component parts of the procedure regardless of whether the same physician (or physician group) furnishes the entire procedure. This policy is consistent with the general fee schedule principle that payment for physician work be made on the same basis without regard to the specialty of the physician performing the procedure. This proposal was made with the understanding that there would be new CPT codes for these procedures effective for services furnished in 1992, and the work on the new codes has been completed. The RVUs for the new codes are listed in appendix B of this final rule.

(The RVUs for S&I services continue to be based on the relationships established under the radiologist fee schedule.)

One facet of our proposal was that the multiple surgery payment reduction would apply to additional services associated with the procedure other than the radiological aspect (S&I) and the primary surgical aspect of the procedure. Under this final rule, this reduction will not be made for the additional services if the RVUs assigned to the additional services reflect that a multiple surgery reduction is already included. The RVUs assigned to these codes generally take the reduction into account.

[Undervaluing of Interventional Radiology]

Comment: Several commenters believe that interventional radiology services have been undervalued in the RVS because interventional radiology is a new branch of medicine that is not well understood. They noted that the radiological portions of the interventional procedures, the S&I, are valued based on RVUs originally established under the radiologist fee schedule. One commenter believes that the radiologist fee schedule RVS was essentially charge-based, rather than resource-based, and that carrying these relationships forward denies interventionalists parity with other specialties, creates poor incentives to deliver cost effective medicine, and results in an inequitable distribution of compensation. Other commenters recommended that the radiologist fee schedule values be maintained for the S&I procedures, while the surgical components reflect values for the services if furnished by both radiologists and other physicians, so that there will be no differential in payments based on specialty designation.

In addition, it was noted that interventionalists have traditionally reported their services under two very different coding methods: one using complete procedure codes and one using a mixture of S&I radiological codes and surgical codes. The commenter indicated that the dual system yielded a very wide range in fee levels and that a total re-valuation of interventional radiology procedures was in order.

Response: We hope that the adoption of new CPT codes and the adoption of our proposal to discontinue complete procedure billing will resolve many of the problems that have existed in the subspecialty of interventional radiology. There have been studies, surveys, and meetings that included representatives

of several medical specialties in coming to agreements on the appropriate coding and valuation of these procedures.

While some disagreements remain, we believe that all parties involved have acted in good faith to make the new coding system work. Under the fee schedule, Medicare will pay the same amount for the total procedure regardless of the number of physicians or physician specialties involved.

[Payment Levels]

Comment: Some commenters compared patient outcomes and payment levels for interventional procedures with those for similar procedures performed in the operating room under general anesthesia and indicated that interventional radiologists should not be discouraged by low payment levels from furnishing these services.

Response: It is our responsibility to make appropriate payments for services based on the relative resources required to furnish the services. It may be possible to take these considerations into account in future revisions of the RVUs.

[Complete Procedure Codes]

Comment: Some commenters disagreed with our interventional radiology proposal. One indicated that past attempts to simplify billing for these time-consuming services into a fair and simple mechanism (complete procedure) was being replaced by a split-billing policy that would probably create chaos.

Response: While the use of the complete procedure codes has obvious simplicity, the use of these codes causes problems if a team of physicians is involved in the procedures. We believe that it is appropriate to pay the same amount for these procedures whether a radiologist performs the complete procedure or whether multiple physicians perform different aspects of the procedure. Our proposal, stated in very general terms in the proposed rule, had the overwhelming support of the radiologists who commented on the issue.

f. *Radiation oncology.* The proposed rule indicated that, under the fee schedules for radiologist services, the national RVS did not provide for payment differentials based on the equipment used in the delivery of radiation therapy services. This was primarily because the CPT coding system had not generally based its procedure descriptions on the type of radiation therapy equipment used before the 1991 edition. In the past, several carriers had instituted local codes for

use in making payment differentials, and because of the long-standing status of those local codes, the carriers were permitted to continue to recognize them for payment purposes. We proposed that any future change in the technical component RVUs to reflect energy differentials would be budget neutral, and that local codes and RVUs that reflect equipment would not be used under the physicians' fee schedule effective for services furnished beginning January 1, 1992. In addition, we proposed to change the distribution of the RVUs assigned to CPT codes 77336 and 77370 (radiation physics consultations in support of the therapeutic radiologist) to technical component-only codes.

[Association With Diagnostic Radiology]

Comment: Several commenters believe the fundamental assumptions of the Harvard study, particularly regarding radiation oncology as compared to medical oncology, were incorrect. Many radiation oncologists commented that they believe that their subspecialty has been substantially harmed by its association with diagnostic radiology and that payment reductions on the basis of overvalued procedures in recent years were directed to diagnostic radiology and affected them inappropriately. Some commenters requested that radiation oncology be reviewed independently of diagnostic radiology because the former represents a clinical practice that deals with the medical and emotional needs of cancer patients and their families. We received a comment from one radiation oncologist with a hospital practice who indicated that the proposed fee schedule was a small, but reasonable, initial step toward equitable financing for health care and that the transition to "front-loading" payments and a mastery of the CPT coding system have resulted in significant increases in income per course of treatment despite reductions in payments for radiologist fee schedule services in 1989 through 1991.

Response: Section 1848(b)(2) of the Act required the Secretary to base the RVUs for the physicians' fee schedule on those established under the radiologist fee schedule with appropriate modification to adapt them to those established for physicians' services generally (the Harvard study). Thus, we believe it is consistent with the legislation to retain the existing relationships for the physician work portion of radiology services that were established under the radiologist fee schedule. Congress did not distinguish between diagnostic radiology and

radiation oncology with respect to payment determinations in the same way that it made special provisions for nuclear medicine and portable x-ray in Public Law 101-239 and Public Law 101-508. However, as indicated elsewhere in this final rule, we have adjusted the RVUs for interventional radiologic service to meet new coding requirements, and we are adjusting the technical component RVUs for radiation oncology services.

[Bundling of Services]

Comment: One commenter noted that the radiologist fee schedule RVUs for the weekly treatment management codes were established specifically for Medicare patients and represent a bundled package that includes up to five physical examinations per week, monitoring of the patient's progress, the reading of port films, family counseling, off-hours evaluations, conferences with family and referring physicians, interpretation of laboratory and x-ray services, and other services. Also, the commenter stated that this negotiated bundling of services into one package saved money for Medicare patients and that the drastic reductions in payments for these codes represents "poor faith negotiations" on our part.

Response: It is true that our adoption of weekly treatment management billings coincident with the implementation of the radiologist fee schedule relieved the Medicare program and beneficiaries of the responsibility of paying for the types of services mentioned by the commenter. It is also true that the replacement of daily billing with weekly treatment management billing significantly benefited radiation oncologists by removing the coverage requirement that the physician personally examine the patient during each treatment session in order to establish that a covered service was furnished. That change in policy permitted the radiation oncologist to be paid for management of the patient's individual treatments that were actually furnished by nonphysician personnel. The policy was established with the understanding that the physician would examine the patient as necessary and that a physician would be available to intervene should problems arise.

[Technical Component Values]

Comment: Many commenters indicated that the technical component values for radiation therapy oncology services under the radiologist fee schedule did not take into account the cost of furnishing these services in freestanding settings (nonhospital)

because the ACR did not have reliable data on these settings. All believe that the situation would be much worse under the new fee schedule, and it was suggested that many oncology centers would have to close. Some commenters estimated that radiologist fee schedule payments covered only from about one-half to two-thirds of the costs of furnishing technical component services in these centers and studies performed by the Association of Freestanding Radiation Oncology Centers (AFROC) and Professional Medical Resources, Inc. were submitted to support this position. Some commenters noted that it is possible to run radiation oncology centers at lower costs with less sophisticated technical equipment, but that patient care and curability is compromised in these situations. Some suggested that payments for the professional component of the service be kept at a high level in order that payments for professional services can continue to subsidize low payments for the technical component of the services. Many commenters suggested that the appropriate mechanism for payment for technical component services is through cost-based technical component payments, and some noted that this suggestion was in accordance with the recommendation of the PPRC that technical payments should not be reduced based upon the assessment that professional radiology services were overvalued.

Response: The issue of the level of technical component payments for radiation oncology services furnished in freestanding centers has been a matter of controversy for many years, particularly since the implementation of the Medicare radiologist fee schedule on April 1, 1989. We have had many discussions with groups representing radiation oncologists and radiation oncology centers who believed from the beginning of the radiologist fee schedule that the technical component RVUs were inadequate. They expressed their concerns in comments made to the interim final rule on the radiologist fee schedule published on March 2, 1989 (54 FR 8994). Among their concerns about the RVUs created by the ACR, and adopted by us as the Medicare national radiology RVs, was a perceived bias toward valuing these services in favor of the professional component at the expense of the technical component. They believe that there was not adequate information about the costs of furnishing radiation oncology treatments and that this factor resulted in RVUs that were too low in relationship to the costs of furnishing the treatment.

In early 1991, representatives of one of the organizations representing radiation oncology centers, AFROC, presented us with the results of two studies of the costs of furnishing radiation oncology services in these centers. One study was the result of a survey of AFROC's members that categorized centers based on the type of equipment used. The study concluded that radiation therapy treatments cost about 47 percent more than payment amounts under the Medicare radiologist fee schedule. A second study done by Professional Medical Resources, Inc., under contract from AFROC, made similar conclusions about the costs of furnishing radiation oncology technical component services.

One major concern we had about analyzing the adequacy of payments for these treatments was whether appropriate patient utilization levels were used to estimate the per treatment cost since we do not believe that we are under any obligation to make inefficient, or inappropriately located, centers viable. In the two studies under the auspices of AFROC, the statistics on patient load, total annual treatments, and staffing levels were similar and consistent with published industry standards.

We reviewed the two cost studies submitted by the industry. We excluded data for centers operating at a low volume of services. Specifically, we considered any facility performing fewer than 3,000 treatments annually to be an outlier. Also, we removed data from one facility where the volume level was so large we believed there was an error. The industry studies did not take into account the fact that we were planning to increase the technical component allowance for two radiation physics codes by reclassifying the entire relative value as a technical-component-only service. Also, the studies did not recognize a recently implemented decision to pay for the technical component of port films. This adjustment to the study data increased the number of relative units used in calculating the adequacy of payments to radiation therapy centers.

As a result of our further analysis of the industry data, we have concluded that we should increase the relative values assigned to the technical components of radiation therapy services by 14.2 percent to reflect the costs of efficiently operated centers. This compares to an approximate 43 percent increase requested by the industry. Also, the 14.2 percent increase was based on a comparison between the estimated costs of radiation therapy centers as compared with 1991 radiology

fee schedule payment amounts. Finally, we compared the results of our analysis of the industry data with hospital cost data which we calculated based on an analysis of hospital outpatient bills. We determined that our proposed payment level after the 14.2 percent increase is about 70 percent of estimated hospital costs.

[Radiation Savings]

Comment: Some commenters indicated that a comparison of the costs of treating patients with certain kinds of cancers with radiation with the costs of treating the same disease with surgery would show that treatment with radiation would save money.

Response: As we indicated in response to earlier comments, we are required to make appropriate payments for services under the fee schedule based on the relative resources required to furnish the services.

[Payment Differentials]

Comment: Most of the commenters who addressed the issues of payment differentials to reflect energy levels of the equipment used suggested that it would be appropriate to collect more data before establishing differentials and that nothing should be done at this time. Some commenters indicated that technical component payments should cover the costs of supplies and nonphysician staff, that the costs of the treatment unit is not the simple function of energy as implied by the new CPT codes, and that payments should not be based on energy levels. A few commenters supported the creation of RVUs based on energy levels. One recommended collecting data on billings under the new treatment delivery codes since March 1991 for use in promulgating energy-based RVUs through this final rule. The commenter indicated that, without energy differentials, it is impossible to pay based on the real capital and operational costs of a treatment machine. A few commenters indicated that the radiation oncology treatment delivery codes do not take into account the "effective energy" of cobalt machines. It was suggested that it was inappropriate to provide for different payment levels for five and six megavoltage units and that this classification would encourage use of higher cost equipment at the six megavoltage level over cobalt machines.

Response: In accordance with the views of the vast majority of commenters on this issue, we have decided to continue our policy of having no payment differential to reflect the

energy-specific treatment delivery codes the CPT system instituted in 1991. We believe that if we did institute these new RVUs for these codes, this should be instituted on a budget-neutral basis, and we are concerned about the effect that lower RVUs would have on many facilities that only furnish low-energy services. In 1992, we will continue to value the treatment delivery codes based within the groupings of "simple", "intermediate", and "complex" without a further energy-specific payment differentiation. We believe the commenter who is concerned about the energy thresholds of the CPT treatment delivery codes should express these concerns to the appropriate component of the AMA responsible for the CPT.

[Global Payments]

Comment: One commenter suggested that the development of global fees for radiation oncology could result in more uniform, high quality radiation therapy at a lower cost. Another commenter indicated that the nature of the radiation oncologist had changed in recent years to de-emphasize payments for the delivery of treatment and increase payments associated with designing treatment courses. The commenter indicated that the RVS constructed by the Harvard team for radiation oncology failed to recognize this "front-loading formula." Several commenters noted that the proposed payment system has no way of indicating that electron treatment is being furnished. The commenters indicated that the much higher costs of electron therapy, including increased time and higher physics and engineering costs associated with machines capable of producing electrons, should be recognized. Some said that if both photons and electrons are billed on the same day, the claims would be treated by the carriers as duplicate services. It was suggested that the descriptors for the 20+ MeV energy range be changed to read "20+ MeV or Electrons" so that there is assurance that capital investment and operational cost recovery would be recognized in payments for electrons.

Response: The RVUs assigned to radiation oncology professional services under the physicians' fee schedule are based on the RVUs established under the radiologist fee schedule for existing CPT codes. We believe the idea of global payments for radiation oncology services has merit and should be considered in the future. As far as changing coding descriptions as suggested by the commenters, these matters should be addressed to the appropriate body of the AMA.

[Local Code Discontinuation]

Comment: The vast majority of commenters from the field of radiology agreed with our proposal to discontinue the limited recognition of local codes for the technical component of radiation oncology services. Several commenters objected to our proposal to discontinue local carrier codes for radiation oncology that take into account varying energy levels of the equipment used in furnishing the services. They noted that there are several community-based, not-for-profit radiation therapy centers, particularly in Texas, Arkansas, and Louisiana, that have a history of a locally-determined basis of payment that should not be eliminated simply to achieve uniformity in payment policy. Some commenters noted that the RVUs established by the Part B carriers for these local technical component codes were, in fact, cost-based, unlike the RVUs published in the proposed rule for radiation treatment delivery.

Response: We are adopting our proposal to discontinue local radiation oncology codes and local energy-based RVUs since we believe that this local coding is inconsistent with the goals of a national fee schedule for physicians' services based on a resource-based RVS. We believe the higher RVUs we are establishing for the radiation treatment codes in this final rule will ease the problems the commenters foresee in eliminating local codes for these services.

[Professional and Technical Component Codes]

Comment: Nearly all commenters agreed with our proposal to change CPT codes 77336 and 77370 to technical-component-only codes and suggested that it would be important to clarify the RVUs assigned to the professional component and to the technical component of the other physics codes to eliminate variations in carrier interpretations of the appropriate payment policy. A national organization of community radiation therapy centers that only bill for the technical component of radiation oncology services indicated that our proposal did not go far enough in recognizing which CPT codes represent services that are, in fact, not furnished by physicians except in rare instances. The group suggested that all codes in the 77300 series of the CPT (medical radiation physics) are technical-component-only and are not payable to physicians except if furnished "incident to" a physician's service by a physicist employed by the physician or if personally and directly furnished by the

physician without the intervention of nonphysician personnel. Some commenters indicated that the physician's services associated with physics codes are payable through the treatment planning codes.

Several commenters indicated that the remaining physics and dosimetry codes represent procedures, performed by the physicist or other designated person for individual patients, that have a professional component to pay the physician for his or her analysis, interpretation, and implementation of the service. A few radiation therapy physicists expressed their concerns about the payment policy applicable to medical physics codes other than the two physics codes for which the policy has been clarified. One commenter indicated that the radiation oncologist receives the professional component for physics services while the physicist who actually furnishes the service is paid for the technical component. He indicated that he had never seen a physician perform a treatment plan on a computer or make a treatment device and that physicists rarely do a dose calculation or microdosimetry. He stated that the physicist should receive the professional component of these procedures and that the technical component should be paid to the facility for the equipment necessary to perform the service. Another physicist said that the medical physics codes were developed as a way to pay physicists for their services to cancer patients and suggested that the professional component of these codes should only be legitimately billed by a physician if the physician contracts with the physicist who furnishes the service. Several other commenters suggested that most radiation therapy physicists have doctor of philosophy (Ph.D.) degrees and that they should be able to bill Medicare for their professional services rather than receive payments for their services indirectly through radiation oncologists.

A CMD commented that most radiation oncologists define their professional component services to hospital patients in connection with these codes as reviewing dosimetry calculations done by nonphysician personnel, selecting appropriate isodose plans, designing treatment devices, etc. He suggested that all of code 77370 should be paid as technical-component-only costs to hospitals only. A hospital could then contract with physicians to furnish these services and claim the costs of the physician services on the cost report.

Response: We believe the elimination of professional component values for

these codes will resolve any misunderstandings about these two codes. As for the other physics codes, our current policy is that the professional component of the codes is payable for services furnished to hospital inpatients and outpatients if the physician personally performs the service. If nonphysician personnel perform these services for provider patients, the services are payable as hospital services under the appropriate payment provision.

We are continuing to obtain as much information as we can on the circumstances under which physics services are furnished, in order to determine the appropriate payment mechanism for these codes if the services are furnished to hospital patients, in view of the requirement in § 405.550(b)(3) that, in order for payment to be made by carriers, services to these patients must ordinarily require performance by a physician. We believe there are problems with the designation of professional component RVUs to several of the radiation physics codes, and we will continue to consider this matter while keeping the current policy in place. We believe, however, based on the CPT descriptions of the applicable codes, that making itemized payments for professional components of several of the physics codes duplicates payments already made through physician billings for treatment planning, treatment simulation, and weekly treatment management. We invite any information from experts in this field that will allow us to clarify this matter in the future.

[Hyperthermia Services]

Comment: One commenter indicated that the RVUs assigned to hyperthermia services (CPT codes 77600, 77605, 77610, 77615, and 77620) are already significantly undervalued relative to the cost of performing the procedures. The commenter stated that Medicare pays only about \$900 for the technical component of furnishing a course of this treatment to a patient although the technical component costs exceed \$9,000.

Response: We based the technical component RVUs for this service under the fee schedule on the estimated average allowances for each technical component service based on the radiologist fee schedule. Section 1848(b)(2)(A) of the Act requires us to base the RVUs for radiology services under the new fee schedule on the RVUs established under the radiologist fee schedule with appropriate modification to adapt the RVUs to those established under the Harvard study. The technical

component RVUs are based on 1991 allowed charges for the service. We do not believe sufficient evidence has been furnished to justify an adjustment to the RVUs for this service.

g. Low osmolar contrast material (LOCM). Divergent payments exist among carriers for LOCM, also known as non-ionic contrast material, for radiological studies. We proposed to make separate payment for LOCM in intravenous radiological procedures if it is used for patients with specified characteristics. We invited comments on this proposed policy, which was based largely on criteria developed by the ACR. We also invited comments on appropriate payment levels for LOCM.

[Separate LOCM Payments]

Comment: Nearly all commenters who addressed the subject approved of our proposal to recognize separate payments for LOCM, but they indicated that LOCM should be payable as a drug. In addition, many were concerned that the proposal was inconsistent with the \$20 million limitation on payments for new technologies covered for the first time. One commenter indicated that LOCM are not new drugs, but that we arbitrarily delayed Medicare coverage, thus denying the benefits of LOCM to patients. Some indicated that Congress did not authorize us to include the estimated additional costs for an expanded LOCM coverage policy in the determination of a budget-neutral CF and that we would be exceeding our authority in trying to do so. Many commenters also suggested that it would be inconsistent to include payment for the LOCM in the physician fee schedule, since the materials involved are drugs used by physicians in furnishing services. One organization indicated that other diagnostic agents used in surgery, such as methylene blue and indigo carmine, are considered drugs.

Commenters believe it would be arbitrary to decrease the payment for LOCM since physicians cannot control vendor pricing and physicians could be placed in a "no-win" situation of either risking pain for their patients or absorbing the increased costs of LOCM. Many commenters indicated that the inclusion of the drug in a budget-neutral fee schedule would be contrary to our proposal regarding the coverage of new services and drugs (56 FR 25815). One commenter suggested that it is not possible for any system to add new and different elements, with their own inherent costs, and expect to provide them within a prior budget framework that did not include them. Several commenters indicated that the use of LOCM is another example of the spread

of the use of high technology in response to the malpractice issue.

Other commenters are concerned that we were proposing to lump all of these pharmaceuticals together and to establish a single payment rate for all LOCM. Some commenters believe that this approach fails to recognize the fact that LOCM are single source Food and Drug Administration (FDA)-approved drugs and that it would be a departure from our longstanding policy to cover drugs for all FDA-approved indications. One commenter indicated that there is no basis in the law or other policy directive to abandon this policy for LOCM and that the proposal to treat LOCM differently from other drugs appears to be based solely on economic grounds. The commenter suggested that, while we have proposed the use of cost-effectiveness in making coverage decisions, the regulations at 54 FR 4302 have not been finalized nor have any guidelines been issued concerning how we might implement the use of this criterion. A few physicians questioned the wisdom of switching to LOCM because the matter of benefits received versus the increased costs has never been sufficiently explored.

Response: The matter of a uniform, national policy on separate payments for the higher incremental costs associated with the use of LOCM in diagnostic procedures is an unresolved issue carried over from the radiologist fee schedule. (Payment of the costs associated with the use of high osmolar contrast media has previously been recognized through the technical component of the diagnostic procedure codes.) Section 2562.I. of the MCM instructed carriers to freeze their policies on separate payments for LOCM under the radiologist fee schedule to the policies in effect during the base period for that fee schedule. Of course, the implication was that we would establish a uniform payment policy if we obtained additional information from the ACR and other sources.

Insofar as the coverage criteria are concerned, all contrast media are covered whether LOCM or the lower priced product is furnished. However, we will only pay the higher payment level for LOCM if certain specified conditions are met. In all other circumstances, payment for the contrast media is included in the technical component allowed for the procedure. When the radiologist fee schedule went into effect in April of 1989, our primary concern was the considerable additional costs associated with the use of LOCM since there is little scientific evidence

that the existing contrast product presented any substantial health risk to the great majority of patients.

Based on the findings of studies and the development of criteria by the ACR as to the appropriate usage of LOCM, we now believe that we can establish a national policy on separate payment for LOCM. Since the payment for this product will be made outside of the fee schedule, the \$20 million limitation set forth in section 1848(c)(2)(B)(ii)(II) of the Act does not apply.

It was our intention to establish RVUs for the Level 2 HCPCS code for LOCM (A4648) that would be used to compute payments in all instances meeting one of the payment criteria. Based on the comments received, we have determined that this is not feasible because of differences in the basic drugs in question, different concentrations associated with each drug, and different dosages used for different procedures.

In accordance with the nearly unanimous view of the commenters, we have decided to pay for LOCM, if the patient meets the required criteria, under the standard methodology for payment of a drug furnished incident to a physician's service generally with one additional condition to prevent duplicate payment. That is, we will base payment on the lower of the estimate of the actual acquisition cost (determined based on the carrier survey of the actual invoice price paid by the physician) or the national AWP of the drug less 8 percent. The 8 percent reduction is in recognition of the fact that the technical component RVUs for these procedures take into account the use of high osmolar contrast media, which average about 8 percent of the cost of LOCM, and full payment for the LOCM would result in our paying for 2 different types of contrast media in connection with the same procedure. We believe the approach we are adopting is preferable to a reduction of the technical component RVUs associated with these procedures since the existing RVUs will be appropriate in making payments for procedures furnished to patients who do not meet any of the specified criteria, and if we reduced the technical component RVUs, a new separate payment would have to be made for the high osmolar contrast media.

This approach meets the concerns of commenters who indicated that the assignment of RVUs to LOCM would lower the CF applicable to their services and those who indicated that it would be unreasonable to treat LOCM differently than other drugs are treated under the fee schedule. It does not meet the concerns of commenters who believe that the use of LOCM should either be

universal or at the physician's discretion (see the next comment and response), since no payment will be made for LOCM in the case of patients who do not meet one of the specified criteria.

[Conditions for Payment of Services for High-Risk Patients]

Comment: Many commenters approved of our proposal to recognize separate payments for LOCM but objected to the proposed conditions under which the payment may be made only in the case of high-risk patients. Some commenters indicated that the criteria should be flexible to allow for the medical judgment of the physician as to the use of contrast media as set forth in the ACR's position on the use of LOCM and that the omission of this criterion made it misleading for us to claim ACR identification with this proposed policy. The commenter stated that a physician's decision to prescribe a particular drug takes into account the patient's clinical condition, the potential side effects of the drug and its alternatives, and the potential diagnostic and therapeutic benefit to be achieved. Further, Medicare policy does not permit carriers and intermediaries to second-guess physicians when they prescribe drugs for FDA-approved indications.

Commenters indicated that the payment criteria should take into account procedures involving sensitive areas of the body such as the hand, procedures involving patients who are frightened by the injection of contrast media, infants, patients with phlebitis, and patients for whom adequate history or laboratory data are not available. Some commenters recommended that payment for LOCM be made universal, rather than restricted for selected patients only, and believe this would reduce the costs. It was noted that most hospitals, including military hospitals under Federal government control, have gone to universal use of LOCM for intravenous injections.

Some commenters referred to the studies conducted in Japan and Australia to demonstrate the benefits of non-ionic vis-a-vis ionic contrast media and the high costs of treating patients who have severe contrast reactions to ionic media. They suggested that there is a greater risk of severe reactions if the patient has no risk factors and receives high osmolar contrast media than if a high-risk patient receives LOCM. Several commenters indicated that they were at risk for legal liability should a reaction occur during a procedure in which they did not use this type of contrast material, and that there should be some provision made to relieve them

of this responsibility. They noted that the use of LOCM is of greatest benefit to those older patients, such as Medicare beneficiaries, whose kidneys may have difficulty handling the high osmolar contrast media.

A CMD suggested that the criterion of "generalized severe debilitation" was open to interpretation, and that the phrase "comatose or obtunded patients" better defines the condition of these patients. Several commenters suggested that the use of LOCM was frequently indicated in intra-arterial (specifically intracoronary), intrathecal, and intracavitary injection and that it was indicated in coronary arteriograms, cardiac catheterizations, pulmonary arteriograms, and extremity arteriograms. One commenter referred to a study conducted by Johns Hopkins that indicated that the costs of treating adverse reactions from contrast media injected during cardiac catheterization may equal or outweigh the additional costs for LOCM.

Response: We are adopting the proposed criteria for making separate payment for intra-arterial as well as intravenous injections, because we believe the criteria for paying separately for LOCM are equally appropriate for these types of administration. In addition, we will instruct the carriers to make separate payments for LOCM in connection with all intrathecal injections. For diagnostic procedures furnished to beneficiaries who are neither inpatients nor outpatients of any hospital, carriers will pay separately for LOCM in the case of all intrathecal injections and for intravenous and intra-arterial injections if it is used for patients with one or more of the following characteristics:

- A history of a previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting;
- A history of asthma or allergy;
- Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmias, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension;
- Generalized severe debilitation; or
- Sickle cell disease.

We decided not to adopt the ACR's criterion that would sanction separate payment for LOCM in any circumstances when, after due consideration, the radiologist believes that there is a specific indication of its use. We believe this liberal criterion would undo the purpose of having payment criteria at all. Based on the

best information we have, the alternative contrast media are acceptable for most usages and should not be considered dangerous drugs. However, we agree that LOCM provides an additional measure of safety for certain high-risk patients.

We reviewed the other suggested indications for the use of LOCM and believe either insufficient information was presented upon which to adopt the additional criteria, or the concerns of the commenter were sufficiently addressed through the adopted criteria. For example, we believe the suggestion that LOCM are indicated in all cardiac catheterizations and several types of arteriograms is adequately addressed through the cardiac dysfunction criterion. Further, in situations in which adequate history or laboratory data are not available, we believe the commenters are referring to emergency situations in which the patients would generally be hospital patients. In these situations, payments for LOCM will be made through an intermediary, rather than a carrier, payment mechanism.

[LOCM Price]

Comment: Some commenters suggested that the issue of the high costs of LOCM should be addressed to the manufacturers of the drug.

Response: We have no authority to interfere with prices manufacturers charge for their products.

h. *Nuclear medicine.* We proposed to change the designation of CPT codes 78990 and 79900 (the furnishing of diagnostic and therapeutic radionuclide(s)) associated with nuclear medicine procedures to technical-component-only codes, because the codes simply represent the substance used in the procedures rather than a service including physician work.

[Integration of RVUs for Nuclear Medicine]

Comment: Some commenters questioned the validity of integrating the RVUs for nuclear medicine procedures established under the radiologist fee schedule into the overall fee schedule. They noted that specialists in nuclear medicine believe the procedures they furnish were undervalued under the radiologist fee schedule and that Congress provided a special payment mechanism for them in 1990 and 1991 in recognition of this situation. They believe the new fee schedule only makes this situation worse and nuclear medicine should have been evaluated separately. They suggested that the RVUs for nuclear medicine procedures be raised by 20 percent. Some commenters indicated that the Harvard

team's methodology should be used to establish RVUs for nuclear medicine procedures as well as for radiological services generally. Several specialists in nuclear medicine strongly supported the higher RVUs for single photon emission computed tomography (SPECT) procedures, because SPECT procedures detect disease not seen with conventional modalities.

Response: We recognize nuclear medicine is both a separate specialty and a subspecialty of radiology. However, nuclear medicine procedures are coded as radiology procedures in the CPT, and Congress has, at least in one instance, included nuclear medicine procedures in the definition of radiology services (section 1833(a)(2)(E)(i) of the Act). As required by section 1848(b)(2)(A) of the Act, the values for individual radiology procedures have the same relationships to other radiology procedures under the physicians' fee schedule as they had under the radiologist fee schedule. We do not believe we have the discretion to use RVUs established in any other manner. While Congress did establish a special payment mechanism for nuclear medicine procedures furnished by certain physicians from April 1, 1990, through December 31, 1991, that provision did not include an ongoing increase in the values assigned to these services relative to other radiology services.

In addition, to integrate the radiologist fee schedule into the physician fee schedule, we split the radiologist fee schedule RVUs into work, practice expense, and malpractice components and multiplied the radiologist fee schedule work values by a rescaling factor. The rescaling factor is equal to the unweighted mean ratio of the Harvard work values to radiologist fee schedule work values for the 55 services surveyed by Harvard in the Phase I and Phase II studies. For this final rule, however, we calculated the rescaling factor based on the mean ratio of the Harvard study to the radiologist fee schedule work values for the 55 services surveyed in Harvard Phase II and an additional 10 services surveyed in Harvard Phase III.

Rescaling nuclear medicine services separately using this different methodology and the additional services would result in lower nuclear medicine work values than if they are rescaled together with other radiology services.

[Diagnostic Radionuclide]

Comment: Several commenters indicated that they supported the proposed policy to permit individual Medicare carriers to pay a separate fee

for furnishing a diagnostic or therapeutic radionuclide under CPT codes 78990 and 79900 (56 FR 25808), because this policy specifically recognizes the right of each physician to select the appropriate radionuclide for a particular patient. The organizations that represent the interests of physicians who specialize in nuclear medicine and others in the field suggested that a national radiopharmaceutical price list be established and enclosed a summary of a limited survey of the costs of these substances.

Response: The proposal in question was made only to clarify a minor error in the original publication of the RVUs under the radiologist fee schedule (54 FR 9023), that is, the listing for appendix B indicated that carriers would establish RVUs for the global, professional, and technical components of CPT codes 78990 and 79900. It later came to our attention that these two codes represented only the radionuclide itself and did not represent the professional components. Our proposal was intended to reflect this fact and was not intended to have payment implications. Payments for radionuclides under the physicians' fee schedule will be made in the same fashion as they are made under the radiologist fee schedule. That is, payment will be made for the radionuclide in addition to the payment for the nuclear medicine procedure, and the payment should be related to the acquisition cost of the substance. Organizations representing physicians who specialize in nuclear medicine are compiling a price listing of radionuclides that we plan to share with the carriers to assist them in properly pricing these substances.

[Nuclear Medicine Site of Service]

Comment: Some commenters indicated that the vast majority of nuclear medicine procedures are performed on a hospital outpatient basis and requested that the site of service differential not be applied to nuclear medicine procedures.

Response: As discussed in the proposed rule (56 FR 25835), we are excluding radiology services from the application of the site of service differential because most of the practice expense for these services is accounted for by the technical component. Nuclear medicine procedures classified within the 70000 series of the CPT code will be considered radiology services for purposes of this exclusion.

5. Anesthesia Services

a. *Integration of anesthesia services into the physician fee schedule and*

elimination of actual time. Section 1848(b)(2)(B) of the Act requires the Secretary to use, to the extent practicable, the uniform relative value guide, with appropriate adjustment of the CF, in a manner to assure that the fee schedule amounts for anesthesia services are consistent with the fee schedule amounts for other services determined by the Secretary to be of comparable value. In addition, the Secretary must adjust the anesthesia CFs by GAFs in the same manner as the adjustment is made for other physicians' services. In the proposed rule, we proposed to eliminate the use of actual time in calculating payment for anesthesia services under the fee schedule.

Comment: Most commenters objected to our proposal to eliminate actual time and integrate the average time of the anesthesia procedure into the RVUs assigned to anesthesia services. The commenters opposed this proposal for various reasons, ranging from the legal basis of our approach to the impact this proposal would have on certain types of anesthesia practice arrangements.

Some commenters disagreed with our interpretation of the statutory language and Congressional intent regarding the treatment of anesthesia services under the physician fee schedule. They refer specifically to the statutory language discussing the integration of anesthesia services into the fee schedule. Section 1848(b)(2)(B) of the Act requires the Secretary to use, to the extent practicable, a relative value guide, established under section 6102(b) of Public Law 101-239, with appropriate adjustments in the CF, in a manner to assure that the fee schedule amounts for anesthesia services are consistent with the fee schedule amounts for other services determined by the Secretary to be of comparable value. The commenters argue that the legislation clearly anticipates the use of the uniform relative value guide, base units plus actual time, and a separate CF for anesthesia services, under the physician fee schedule.

Many commenters stated that the use of average time instead of actual time would disadvantage certain types of anesthesia practice arrangements, particularly those in teaching hospitals and rural hospitals. According to these commenters, use of average time would redistribute payments from these practice arrangements to other arrangements, such as anesthesia services furnished in ASCs where the average time is less than the national average time. These commenters recommend that we continue to use

actual time and proposed a more restrictive definition of "anesthesia time." These commenters also recommend that time be independently verifiable and believe this verification would be relatively simple to achieve. They stated, for example, that the Medicare conditions of participation could require that operating room nursing records document the start and stop of anesthesia time.

Many commenters also noted that the anesthesia coding system was designed with actual time as a key variable. It is common for the anesthesia codes to subsume a large number of surgical codes whose anesthesia times vary significantly. They noted that significant revision to the coding system would be necessary to accommodate the elimination of actual time.

Response: In the proposed rule, we announced our intention to eliminate the use of the actual time a given procedure takes to perform in determining payment for anesthesia services. As noted, we received numerous comments arguing against this proposal on a variety of grounds. We firmly believe we have the legal authority to eliminate time since the statute only directs us to use the uniform relative value guide "to the extent practicable". We have decided temporarily, however, not to eliminate the use of actual time primarily because of concern that the coding system needs to be refined as a prerequisite for this change.

We have been able to identify certain high volume anesthesia codes that should be subdivided because they encompass a number of surgical codes whose average time unit values vary significantly from one another. We were unable, however, to extend this analysis to anesthesia services with lesser volumes that might also be candidates for further subdivision. Also, we presently lack good data on anesthesia times for teaching hospitals. We are concerned, from discussions with representatives of teaching hospitals and a review of comments from teaching anesthesiologists, that the issue of whether teaching hospitals have significantly higher average times needs further examination.

Since actual time will be retained, we will use temporarily a CF for anesthesia services separate from the CF for all other services under the fee schedule, and we will continue to use the anesthesia uniform relative value guide consisting of base units per procedure and 15- and 30-minute time units for personally performed and medically directed services, respectively. Also, we will continue to follow the provision in

current law requiring that payment for concurrent medical direction services be reduced as follows: 10 percent in the base units for 2 concurrent procedures, 25 percent in the base units for 3 concurrent procedures, and 40 percent in the base units for 4 concurrent procedures. (However, if there are three or four concurrent procedures, and cataract or iridectomy anesthesia is one of the concurrent procedures, there is only a 10 percent reduction in base units for the cataract or iridectomy procedures.)

As required by law, we are adjusting the anesthesia CF to assure that the fee schedule amounts for anesthesia services are consistent with the fee schedule amounts for other services determined to be of comparable value. We determined the extent to which the work component of anesthesia services was overvalued vis-a-vis other procedures and reduced the work component of the 1991 national average anesthesia CF by this percentage. This is further discussed under the section on the methodology for integrating anesthesia services in the fee schedule.

While we have decided to continue temporarily the use of actual time for the final rule, we continue to have serious reservations about paying anesthesia services on a different basis than all other physician services. We also continue to believe the current definition of "anesthesia time" is not precise and leads to wide variation in the reporting of time and is subject to abuse. We will be analyzing the issue of how to pay for anesthesia services in the future.

Among the issues we will be analyzing are the following:

- Whether disaggregating certain anesthesia codes or even returning to surgical codes would make the elimination of actual time more feasible and equitable.
- Whether we should eliminate actual time for the pre- and post-operative period only, that is, retain actual time for the operative period.
- How the definition of "anesthesia time" can be tightened to lessen the variation in actual time reporting.

For the short term, we are revising our definition of "anesthesia time" consistent with the recommendation of the ASA. For this purpose, anesthesia time involves the continuous actual presence of the anesthesiologist (or of the medically-directed qualified individual) and starts when he or she begins to prepare the patient for anesthesia care in the operating room or equivalent area and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient

may be safely placed under post-operative supervision.

Moreover, we are instructing our carriers to closely monitor the use of actual time reporting for high volume procedures. To assist them in this effort, we are sharing information we have developed on average time per procedure.

b. Payment for multiple anesthesia services. The proposed rule did not specifically address the issue of the payment policy for multiple anesthesia services.

Comment: Commenters pointed out that the proposed rule discussed additional payments to surgeons performing multiple surgery or bilateral surgery. There was no discussion of what happens to the anesthesiologist under this situation if time were eliminated.

Response: Historically, we have not had a national payment policy to respond to the circumstances involving an anesthesiologist in multiple anesthesia procedures. Consequently, each carrier determined the payment policy that applied based on historical billing practices. It is our understanding that carriers usually recognized the base unit of the highest valued procedure of the multiple anesthesia procedures and the actual time encompassing the multiple procedures. Because the proposed rule did not specifically address this issue for anesthesia services, the commenters assume that the anesthesiologist would only be paid on the basis of the average time associated with the longest procedure.

This comment is valid even though we are using actual time rather than average time as a basis for anesthesia payments. We are adopting as a uniform policy, for anesthesia services associated with both multiple and bilateral surgery procedures, the policy that recognizes the base unit of the anesthesia procedure with the highest base unit value and actual time that extends over all the surgical procedures.

c. Payment for specialized services furnished by anesthesiologists. The policies of carriers are mixed with respect to recognition of separate payment for the insertion of Swan-Ganz catheters, intra-arterial lines and central venous pressure lines by anesthesiologists. We proposed to allow separate payment for specialized procedures furnished by anesthesiologists if these procedures are furnished in conjunction with an anesthesia procedure or as an unrelated procedure.

Comment: Commenters generally favored our proposal to recognize separate payment for certain specialized

services, coded as medical or surgical codes, furnished by anesthesiologists. These are invasive procedures, sometimes performed pre- or intra-operatively by anesthesiologists in order to place certain monitoring devices that provide important data as to patient condition. The commenters indicate that these services are patient specific, not procedure specific, and it would, therefore, be inappropriate to bundle these services into the base units. Also, because the codes are used by several specialties, they must remain distinct codes. These commenters also recommended that we not include in the regulations the specific codes for the medical or surgical services furnished by anesthesiologists for which separate payment would be allowed. Instead, they recommend that this be included in program operating instructions.

Response: We will allow separate payment for certain specialized medical and surgical services that anesthesiologists furnish separately or as part of the anesthetic procedure only if these services are reasonable and necessary or are not included as services paid under the global surgical fee or otherwise rebundled with the anesthesia service. Our manual instructions will identify the specific medical or surgical services that can be separately recognized and the circumstances under which separate payment can be made. These instructions will identify, for instance, certain anesthesia codes for which separate payments will not be allowed for arterial lines.

Comment: Some commenters noted that the proposed rule was unclear on how acute post-surgical pain management services would be paid. They asked whether these services would be separately paid or included in the post-operative surgical care global fee.

Response: Acute post-surgical pain management services are generally furnished by the surgeon. Under the fee schedule, these services by the surgeon are included in the surgeon's global payment and are not separately billed. We recognize, however, that there are certain special situations when a patient's acute post-surgical pain may be so severe as to require consultation or treatment by another specialist such as an anesthesiologist. Our policy for these situations will be to allow separate billing by the pain specialist if the service is documented as being medically necessary. This policy is consistent with our policy for other instances of concurrent care. If, however, we find that referral to a pain specialist becomes routine, we will

direct carriers to reduce the global payment for the surgery accordingly.

d. Methodology for integrating anesthesia services into the physician fee schedule. The proposed rule described how anesthesia services were integrated into the physician fee schedule. Harvard produced work values for 19 anesthesia services. We used the relationship between the Harvard work value and the base and average time unit value for these 19 procedures to compute work values for the remaining anesthesia services. We computed practice expense and malpractice values by multiplying the 1991 national average CF by the base and average time unit value per procedure and the corresponding anesthesiology specialty practice expense or malpractice percentage. We also factored in the base unit reductions and the lowered time unit values for medically directed procedures. In all, we developed relative values for each anesthesia procedure code for each of the five different types of anesthesia practice arrangements.

We also used this methodology to estimate the number of work, practice expense, and malpractice units for all anesthesia procedures.

Comment: Commenters asserted that there were significant problems with the methodology used to determine average times and to estimate aggregate work, practice expense, and malpractice RVUs for physician anesthesia services. For example, the commenters noted that Harvard used surgical codes that describe specific services such as anesthesia for laparoscopic tubal ligation. We used the base units and average time for code 00806, which includes laparoscopic tubal ligations and 19 other procedures. Also, the commenters noted that the ratios we computed for the 19 surveyed procedures were so widely divergent that, while it is mathematically possible to determine a ratio, one cannot view the resulting number as having any validity. Based on one commenter's analysis, the variability in the ratio of Harvard work values to our estimated average time units showed a range of 55 percent. Under the proposed rule, we equally weighted each ratio to compute a single constant ratio of 24.21. These ratios, however, ranged from a low of 15.89 for code 00806 to a high of 29.41 for code 00142, or a range of 55 percent.

Response: We will not be using the challenged methodology in this rule. The primary purpose of the methodology was to estimate work values for the procedures for which Harvard did not compute work values. Since we are

continuing to use the base units from the uniform relative value guide and time units, it is not necessary for us to compute a rescaling factor to estimate work values for the unsurveyed procedures.

Since the use of actual time is being retained, we developed a different methodology from that in the proposed rule to estimate the extent to which the work component of anesthesia services is overvalued.

For the 19 surveyed procedures, for which Harvard work values were available, we determined the difference, for personally performed procedures, between the average payment under the current base and time unit system and the average payment that would be allowed using the Harvard work values.

The average payment per procedure under the current base and time unit system was determined by multiplying the base and average time unit per procedure by the national anesthesia CF. The national CF for 1991 will be \$19.27. Average time units are calculated from personally performed anesthesia procedures from NCH files for the 9-month period ending June 30, 1991. We lowered the average time unit values by 10 percent to account for the removal of multiple anesthesia services. This adjustment is being made since the Harvard work units do not reflect any multiple procedures while our average time data will include some multiple procedures. We estimate that multiple anesthesia procedures will increase the average time unit values by this percentage. This adjustment of time units actually lowers the percentage by which the anesthesia CF must be reduced. The base unit is the value from the uniform relative value guide (see appendix A in section 8313 of the MCM).

The average payment per procedure under the physician fee schedule payment system was determined based on the Harvard work value; the practice expense and malpractice payment amounts for each of the 19 anesthesia codes were "passed through" by multiplying the current average allowance per procedure by the sum of the anesthesia practice expense and malpractice expense weights. The Harvard work value was placed on the same scale as practice expense and malpractice and multiplied by the general physician CF. The work amount and the "passed through" amounts for practice expense and malpractice were summed.

For each of the 19 procedures, the percentage reduction between the current payment amount and the physician fee schedule payment amount was calculated. The reduction

percentage for physician anesthesia services was determined as the unweighted mean of the reduction percentages for all 19 procedures. Based on this method, the reduction percentage in physician anesthesia work will be 41.7 percent. The new national CF for anesthesia services, without the 1992 update of 1.9 percent, will be \$13.68 which constitutes a 29-percent reduction. This was derived by applying the work reduction of 42 percent to 69.5 percent of the \$19.27 CF, which is the anesthesia specialty work share and adding in the practice expense and malpractice shares totaling 30.5 percent of the current average CF. Algebraically, the formula will be: $((\$19.27)(.695)(.583) + (\$19.27)(.305))$. The \$13.68 CF constitutes an overall 29 percent reduction of the current CF.

For each payment area, this CF was divided into work, practice expense, and malpractice components based on the anesthesia specialty weights of .695, .232, and .073, respectively. Each of these components was multiplied by its respective GPCI and summed. The resultant sum constitutes the anesthesia fee schedule CF for the payment area. This amount is increased to reflect the update factor for physician services for 1992. The transition rules are applied to the anesthesia CF in the same way they apply to all other physician services.

Comment: One commenter referred to analysis it conducted on the 1987 BMAD Procedure File to test the reliability of our proposed average time unit values. This analysis was performed on 54 anesthesia codes, which account for 88 percent of approved charges. This commenter noted that while there is correlation between the averages used by us in the proposed rule and the commenter's average time unit values, there is clearly a consistent undervaluation of the averages.

Response: The commenter failed to note that the time units reported in the 1987 BMAD file are time units that have been rounded up to the next whole number. The data source used in the proposed rule were average time units that reflect the actual time and were not rounded. The rounding can account for as much as a 10-percent increase in average time unit values, which helps explain the majority of the difference between our average values and the commenter's average values. For the 19 procedures for which we estimated the extent to which anesthesia services are overvalued, the average time unit values are approximately 9 percent higher than the proposed average time unit values used in the proposed rule. These final average time unit values are based on a better sample. These final average time

unit values were computed from a 100 percent sample of the Common Working File (CWF) data for personally performed anesthesia procedures for the period October 1, 1990 to June 30, 1991. The increase in average time units means that the reduction in anesthesia payments must be greater, since there is now a larger disparity between the current payment allowance and the physician fee schedule payment.

Comment: One commenter provided an example to illustrate inherent inequities in anesthesia service payments relative to other physician services' payments. It is the commenter's view that this example shows inappropriate cross-linking between anesthesia services and other physician services. The commenter correctly noted that the proposed resource-based RVU for code 00420, anesthesia for removal of a lesion on the back, was listed at 4.79 units. The commenter identified components of this anesthesia procedure (that are otherwise listed as medical and surgical service codes) and attempts to assign resource-based RVUs to these component parts. For code 00420, components would be:

- Pre-operative patient history and physical examination.
- Placement of an intravenous catheter.
- Drug induced induction of coma and paralysis.
- Intubation.
- Mechanical ventilation.
- Placement in the prone position, with danger of heart or breathing dysfunction, and eye or limb nerve injury if not carefully managed.
- Drug induced coma and hemodynamic management for 45 minutes.

The commenter noted that if a medical specialist were to furnish and bill for these services in the intensive care unit, he or she would receive 10 to 11 units as the sum of units for these separately reported services, whereas the anesthesiologist would receive 4.79 units if he or she billed the anesthesia codes, which consists of these and other services.

Response: The proposed value of 4.79 units cited by the commenter was the combined resource-based RVUs developed from base and average time units. This value is no longer valid, since we are continuing to pay anesthesia services on the basis of uniform base units and actual anesthesia time. Despite this, we believe the commenter has overstated the nature of and complexity of activities included in 00420. The 1991 average allowed charge

for this code is approximately \$205. Under the commenter's scenario, there would have been an allowance of \$330 (that is, 11 units multiplied by the national physician CF).

e. Monitored anesthesia care. The OIG has prepared a final report entitled "Medicare Coverage and Reimbursement for Monitored Anesthesia Care". This report recommends that monitored anesthesia care be specifically identified on the claim form with a uniform modifier. We proposed to adopt this recommendation and provide for a uniform modifier to be used with the anesthesia code to identify monitored anesthesia care.

Comment: Some commenters opposed the use of a claims modifier to identify those cases when the anesthesia procedure is performed under monitored anesthesia care. These commenters are concerned that we are only interested in obtaining this data so as to reduce fee schedule payments for anesthesia procedures performed under monitored anesthesia care. These commenters also noted that there is no need to indicate the type of anesthesia selected on the claim form; it is analogous to asking the surgeon to indicate the surgical approach.

Response: We proposed the use of a claims modifier to identify monitored anesthesia care cases to have basic data on the total volume of anesthesia care cases and to be able to identify those anesthesia procedures most commonly performed under this process. It is our intention to ensure that cases being reported as monitored anesthesia care are medically necessary and that cases of much lesser complexity than monitored anesthesia care cases are not being improperly reported as monitored anesthesia care cases. While we do not have plans to revise the payment policy for monitored anesthesia care at this time, we do not rule out this possibility if data and analysis support this approach. A modifier of "QS" will be used to designate a procedure as a monitored anesthesia care procedure.

f. Teaching physicians. We proposed to recognize an attending physician relationship only if a teaching anesthesiologist is involved with a single procedure involving an intern or resident (§ 415.44).

Comment: Some commenters indicated that teaching hospitals would be adversely affected by the policy under which unreduced fee schedule payments would be made only if the teaching anesthesiologist establishes an "attending physician" relationship in a single case involving an intern or resident. These commenters noted that it is the usual practice for a teaching

anesthesiologist to be involved with two concurrent cases involving interns or residents. Many commenters stated that it is a common practice for teaching surgeons and other teaching medical specialists to extend their services to more than one patient concurrently. For example, the resident may perform all aspects of surgery except for the most difficult part, which the teaching surgeon will perform. After the teaching surgeon performs this part, he leaves the remainder of the service, including the closing, to be performed by the resident. The teaching surgeon may then go on to the next operating room to perform the more complex part of the next scheduled surgical procedure. These commenters recommended no action be taken on the teaching anesthesia payment issue until it is undertaken systematically as part of the review of all teaching physician policies. Other commenters favored the policy to apply medical direction payment rules to all concurrent procedures as this established a "level playing field" without regard to choice of anesthesia provider.

Commenters also believe that there is no systematic incentive to use CRNAs instead of residents, because only about 12 percent of all CRNAs practice in academic settings. These commenters further noted that academic centers exist to train residents and the practice arrangements for all specialties are geared to that goal. It is not an issue of "choosing" a resident over a CRNA because of economics; physicians are there to teach residents.

Response: We understand that it is common practice for teaching anesthesiologists to be routinely involved in two concurrent cases and for almost all our carriers to currently recognize unreduced allowances if an anesthesiologist is involved with two concurrent cases. Consequently, our proposed policy could prove disruptive to current anesthesia practices of teaching hospitals if implemented precipitously. On the other hand, we are concerned with the disparity in payment allowances between two concurrent procedures involving residents or other nonphysician anesthetists. While we understand the teaching anesthesiologist issue is not unlike the issues affecting other teaching physicians in concurrent cases, we do not wish to defer action on this matter until we address systematically the issue of coverage of teaching physicians. To give the teaching hospitals the opportunity to adjust their practices, we will continue the policy that allows unreduced payments for concurrent cases involving residents through December 31, 1993. For services furnished after that date,

we will uniformly apply medical direction payment rules to concurrent procedures regardless of whom the anesthesiologist is directing.

Comment: Many commenters objected to our proposed policy regarding the number of concurrent cases a teaching physician could manage, because it would reduce medical school departmental income and the ability of this income to support anesthesia residents. These commenters mention that faculty physician fees make up the large part of departmental income. The proposed policy would reduce departmental income because faculty fees would be reduced. This would result in a decrease in the number of anesthesia residents.

Response: This comment implies that Medicare pays for the cost of residents' services through physician service payments. There is a specific payment mechanism in § 413.86 to recognize the cost of services of interns and residents in approved training programs. For cost reporting periods beginning July 1, 1985, Medicare pays the hospital a prospectively determined hospital specific per resident amount. These payments would be made independent of the amounts recognized for faculty physicians' involvement with interns and residents.

6. Physician Pathology Services

The law requires that physician pathology services be treated like other physician services under the fee schedule beginning January 1, 1992. Of the approximately 1,100 services listed in the pathology section of the CPT, only 57 services qualified as physician services under the proposed rule. The remainder of pathology services are considered clinical diagnostic laboratory services and are excluded from the physician fee schedule by section 1848(j)(3) of the Act. As part of its cooperative agreement with us, the Harvard study team has provided relative values for the physician work associated with physician pathology services. We explained in the proposed rule that while the Harvard findings would allow us to compute payment amounts for the professional component of physician pathology services, section 4104(c) of Public Law 101-508 also requires that we consider an appropriate adjustment to reflect the technical component of furnishing physician pathology services through a laboratory that is independent of a hospital and separate from a physician's office. We proposed to assume that the technical component of physician pathology

services is equal to 15 percent of the 1991 adjusted historical charge.

[Code Omissions]

Comment: Some commenters stated that, in the proposed rule, we listed 57 CPT codes that qualify as physician pathology services and would be included under the fee schedule. Actually, we did not publish this list in the *Federal Register* although these codes are listed in section 5114 of the MCM. One commenter identified the following list of codes that should be considered physician pathology services and is virtually identical to the MCM list. This list follows:

- 80500 Clinical pathology consultation; limited, without review of patient's history and medical records
- 80502 * * * comprehensive, for a complex diagnostic problem, with review of patient's history and medical records
- 85060 Blood smear, peripheral, interpretation by physician with written report
- 85095 Bone marrow smear and/or cell block; aspiration only
- 85097 * * * smear interpretation only
- 85100 * * * aspiration, staining and interpretation
- 85101 * * * aspiration and staining only
- 85102 Bone marrow needle biopsy
- 85103 * * * staining and interpretation only
- 85105 * * * interpretation only
- 85109 * * * staining and preparation only
- 86077 Blood bank physician services; difficult cross match and/or irregular antibody(ies), interpretation and written report
- 86078 * * * investigation of transfusion reaction including suspicion of transmissible disease, interpretation and written report
- 86079 * * * authorization for deviation from standard blood banking procedures (for example, use of outdated blood, transfusion of RH incompatible units), with written report
- 88104 Cytopathology, fluids, washings or brushings, with centrifugation except cervical or vaginal; smears with interpretation
- 88106 * * * filter method only with interpretation
- 88107 * * * smears and filter preparation with interpretation
- 88108 * * * concentration technique, smears and interpretation (for example, Saccomanno technique)
- 88125 Cytopathology, forensic (for example, sperm)
- 88151 Cytopathology, smears, cervical or vaginal (for example,

- Papanicolaou), up to three smears; requiring interpretation by physician
- 88160 Cytopathology, any other source; screening and interpretation
- 88161 * * * preparation, screening and interpretation
- 88162 * * * extended study involving over 5 slides and/or multiple stains
- 88170 Fine needle aspiration with or without preparation of smears; superficial tissue (for example, thyroid, breast, prostate)
- 88171 * * * deep tissue under radiologic guidance
- 88172 Evaluation of fine needle aspirate with or without preparation of smears; immediate cytohistologic study to determine adequacy of specimen(s)
- 88173 * * * interpretation and report
- 88180 Flow cytometry; each cell surface marker
- 88182 * * * cell cycle or DNA analysis
- 88300 Surgical pathology, gross examination only
- 88302 Surgical pathology, gross and microscopic examination
- 88304 Surgical pathology, gross and microscopic examination
- 88305 Surgical pathology, gross and microscopic examination
- 88307 Surgical pathology, gross and microscopic examination
- 88309 Surgical pathology, gross and microscopic examination
- 88311 Decalcification procedure (List separately in addition to code for surgical pathology examination)
- 88312 Special stains (List separately in addition to code for surgical pathology examination); Group 1 for microorganisms (for example, Gridley, acid fast, methenamine silver), each
- 88313 * * * Group II, all other, (for example, iron, trichrome), except immunocytochemistry and immunoperoxidase stains, each
- 88314 * * * histochemical staining with frozen section(s)
- 88318 Determinative histochemistry to identify chemical components (for example, copper, zinc)
- 88319 Determinative histochemistry or cytochemistry to identify enzyme constituents, each
- 88321 Consultation and report on referred slides prepared elsewhere
- 88323 Consultation and report on referred material requiring preparation of slides
- 88325 Consultation, comprehensive, with review of records and specimens, with report on referred material
- 88329 Consultation during surgery;
- 88331 * * * with frozen section(s), single specimen
- 88332 * * * each additional tissue block with frozen section(s)

- 88342 Immunocytochemistry (including tissue immunoperoxidase), each antibody

- 88346 Immunofluorescent study, each antibody

- 88347 * * * indirect method

- 88348 Electron microscopy; diagnostic

- 88349 * * * scanning

- 88355 Morphometric analysis; skeletal muscle

- 88356 * * * nerve

- 88358 * * * tumor

- 88362 Nerve teasing preparation

- 88365 Tissue in situ hybridization, interpretation and report

Response: We are accepting the commenter's proposed list as a valid list of physician pathology services. While most of these codes will have both a professional component and a technical component, only one of these codes, 85109, is a technical-component-only code. No payment will be made by the carriers if these services are furnished to a hospital inpatient or an outpatient by a hospital physician. Other codes, such as 80500, 80502, 85060, 85095, 85097, 85105, and 86077 through 86079 represent professional-component-only services. Addendum B designates the physician pathology codes as having a professional component only, a technical component only, or both a professional and technical component.

We are also clarifying our payment for two other codes. Code 88151 (cytopathology, smears, cervical or vaginal, requiring interpretation by a physician) is, for a hospital outpatient or a nonhospital patient, paid only under the clinical laboratory fee schedule and is, therefore, excluded from the physician fee schedule. This code, however, if billed with modifier 26, will be used to designate the professional component and will be paid under the physician fee schedule if a physician interprets an abnormal smear for a hospital inpatient. This same policy will apply to screening pap smears, code P3001.

Similarly, code 85060 (blood smear, peripheral, interpretation by a physician) if billed with modifier 26, will be used to designate the professional component and will be paid under the physician fee schedule if a physician interprets an abnormal blood smear for a hospital inpatient. If a physician interpretation of an abnormal blood smear is performed for a hospital outpatient or a nonhospital patient, this service is not billed under code 85060. It is considered a routine part of the ordered hematology service (that is, those tests that include a differential white blood count) and is paid under the clinical laboratory fee schedule.

[Clinical Laboratory Interpretation Services]

Comment: Commenters requested that we consider paying for a new category of services, namely, clinical laboratory interpretation services, under the physician fee schedule. They maintain that there are a limited number of clinical laboratory codes for which it is almost always necessary for the laboratory physician to furnish an interpretation. These services cannot be appropriately paid as clinical consultations because they are not always requested by the attending physician although the laboratory physicians assert that their interpretations are necessary for the test to have meaning to the attending physician. They also recommended that we provide for a biannual re-evaluation process of clinical laboratory codes always requiring a physician's interpretation.

Response: During the past year, we have worked with the carriers' medical directors to develop a national list of clinical laboratory codes for which a laboratory physician would furnish a clinical laboratory interpretation service. We are adopting this national list and will periodically review this list to determine if additions or deletions are appropriate. The national list will be included in the Medicare Carriers Manual. This national list includes the following codes:

- 83020 Hemoglobin; electrophoresis
- 83912 Nucleic acid probe, with electrophoresis, with examination and report
- 84165 Protein, total, serum; electrophoretic fractionation and quantitation
- 84190 Protein, urine; electrophoretic fractionation and quantitation
- 85390 Fibrinogen; screening
- 85576 Platelet; aggregation (in vitro), any agent
- 86255 Fluorescent antibody; screen
- 86256 Fluorescent antibody; titer
- 86320 Immunoelectrophoresis; serum, each specimen
- 86325 Immunoelectrophoresis; other fluids (for example, urine) with concentration, each specimen
- 86327 Immunoelectrophoresis; crossed (2 dimensional assay)
- 86334 Immunofixation electrophoresis
- 87164 Darkfield examination, any source (for example, penile, vaginal, oral, skin); includes specimen collection
- 87207 Smear; primary source, with interpretation; special stain for inclusion bodies or intracellular parasites (for example, malaria, kala azar, herpes)

89060 Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine)

We are revising § 405.556, which sets forth conditions for payment of charges for physician laboratory services, to include the newly defined category of services, clinical laboratory interpretation services, and the circumstances under which these services are covered. To be covered, these services must be requested by the patient's attending physician, result in a written narrative report included in the patient's medical record, and require the exercise of medical judgment by the consultant physician. We will allow a hospital's standing order to be considered a substitute for an individual request by the patient's attending physician.

In addition, we are establishing work, practice expense, and malpractice RVUs for clinical laboratory interpretation services. The work values proposed by a national pathology organization were reviewed by our medical advisors. Based on this review, we have determined that the most comparably valued service to the clinical laboratory interpretation service is the brief clinical consultation, code 80500. We are, therefore, assigning the work, practice expense, and malpractice values of the brief clinical consultation to each of the clinical laboratory interpretation codes. We plan to provide for a periodic review process for adding or deleting codes from the list of approved clinical laboratory interpretation services. This process will be part of the RVU process described elsewhere in this preamble.

[Coding Conventions]

Comment: Commenters noted that there are a variety of coding practices among pathologists and differing coding and payment policies among Medicare carriers. Some carriers require that pathologists continue to use the pre-1985 coding convention that indexed codes to organs or surgical procedures rather than to the level of diagnostic skill or difficulty involved in the pathologist's work. Some carriers have other coding guidelines that place all specimens of one type in a particular code and that differ from guidelines of other carriers.

The commenters requested that we instruct the Medicare carriers to adopt the 1992 CPT surgical pathology coding system simultaneously with implementation of the fee schedule. The 1992 CPT system will allow physicians and carriers to reliably and consistently code the same service the same way in all geographic areas.

Response: We intend to adopt the 1992 CPT pathology codes. The carriers will be significantly limited in the extent to which they can use local codes or local interpretations of CPT codes.

[Consultative Pathology Services]

Comment: One of the current criteria for a covered clinical consultation service is that the consultation must relate to a test result that lies outside the clinically significant or expected range in view of the condition of the patient. One commenter suggested that this criterion be revised so as to include circumstances under which the pathologist responds to a follow-up request for interpretation of a "rule out" test that falls in the normal range. This occurs, for example, when the attending physician expects a test to yield an abnormal result in light of other diagnostic information on the patient, but the test result is normal. This commenter recommended that § 405.556(b)(2), which requires that consultative pathology services relate to a test result that lies outside the clinically significant normal or expected range in view of the condition of the patient, be revised by allowing an alternative requirement for the test result to "provide beneficial direction in the care of the patient".

Response: We are not adopting this comment. We believe the language of the current regulation is broad enough to cover this circumstance. We will clarify our interpretation of the regulations in the operating instructions to the carriers to implement the physician fee schedule.

[Surgical Pathology Services]

Comment: Commenters inquired whether the interpretation of a surgical pathology service furnished by a hospital pathologist to a nonhospital patient is a physician service subject to the physician fee schedule or a laboratory service payable on a reasonable charge basis and subject to the inflation-indexed charge (IIC). Commenters also questioned whether the technical component of surgical pathology services would be subject to the rules for purchased diagnostic services when, for example, a hospital pathologist purchases the technical service from an independent laboratory.

Response: This service is a physician service payable under the physician fee schedule. We do not consider the technical component of a surgical pathology service to constitute a diagnostic test.

[Biopsy Interpretation]

Comment: One commenter stated that a neurologist's interpretation of muscle and nerve biopsies involves more work than the pathologist's interpretation of biopsies because the neurologist must correlate the biopsy results with a clinical condition presented by the patient, whereas the pathologist does not. Because the work is different, the commenter believes separate relative values and codes should be established for each.

Response: We do not agree with the commenter. Under the current coding system, there is a single work value for each CPT code. We suggest that the professional association that represents neurologists present their arguments for additional codes to the CPT Editorial Panel. Moreover, the correlation of the biopsy results with other patient findings would be part of a physician visit or consultation and not additional work associated with the biopsy.

[Waiting Time]

Comment: Commenters stated that although the pathologists recommended that the Harvard study include "waiting time" as an element of service for certain pathology services, it was excluded. However, the Harvard study did provide for a surgeon's waiting time. The commenters noted that it would be inconsistent and inequitable to compensate surgeons for surgical waiting time and not to compensate pathologists for waiting time attendant to the same surgery. The commenters recommended that pathologist waiting time attendant to surgical procedures be separately compensated.

Response: We do not agree with the commenter that waiting time should be included as an element in the pathology RVUs, because it was considered by Harvard in the development of the RVUs for surgical services. Unlike surgeons, pathologists are able to perform other work while they are waiting for a surgical specimen to be ready for review. The nature of their work permits them to efficiently use the waiting time if they choose.

7. Charge-based Computation of Practice Expense and Malpractice RVUs

Section 1848(c)(2)(C) of the Act prescribes that the Secretary compute practice expense and malpractice RVUs by applying historical practice cost percentages to a base allowed charge for each service. For emergency department services (CPT codes 99281 through 99285), we proposed to use the practice expense and malpractice percentages for emergency physicians

(30 percent for practice expense and 4.5 percent for malpractice) that would be applied directly to the base allowed charge. Under the proposed rule policy, we would not determine the average percentage division of resources among all specialties furnishing these services.

[RVUs for Emergency Department Visits]

Comment: Some commenters objected to our method of calculating the practice and malpractice RVUs for emergency department visits. According to the commenters, the language in the regulations does not distinguish emergency department visits from other services and, consequently, does not allow for the exception described in the preamble to the proposed rule.

Some commenters also objected to our exception for emergency department visits because, in their view, this exception would be counter to the design of the practice expense RVU, which should reflect overall practice expenses and not actual practice expenses for furnishing a specific service. Further, they also stated that emergency physicians would be penalized by the proposed policy because the practice costs percentages of non-emergency physicians furnishing emergency department visits would not be recognized. Additionally, these commenters believe the practice expense and malpractice RVUs should recognize the expense of maintaining an office and the inconvenience of seeing patients in the emergency room when non-emergency physicians furnish emergency department visits. Lastly, some commenters stated that emergency department visits may have higher work values than other visits. If this is the case, reducing the practice expense RVUs without recognizing the higher work values could result in emergency department visits being undervalued. These commenters stated that because internists, family and general practitioners furnish over 90 percent of emergency department visits, the practice expense and malpractice RVUs should reflect the practice costs percentages for these specialties. Some commenters also urged that any physician be allowed to bill using the emergency department visit codes. Some commenters supported the practice cost percentages we proposed for emergency department visits.

Response: For this final rule, we have decided not to make the proposed exception because emergency medicine is not recognized in the Medicare charge data as a distinct specialty and we do not know the percentage of emergency department visits provided by

emergency physicians or other specialists. As we have no evidence indicating that a substantial percentage of emergency room visits are furnished by emergency physicians, we do not believe it is fair to assume that all emergency room visits are performed by emergency physicians. The practice expense and malpractice RVUs are higher for emergency room visits in this final rule than under our proposed policy, because we used the practice expense and malpractice shares of all specialties reporting this service.

[Determining Practice Expense and Malpractice RVUs]

Comment: Some commenters raised concerns about the methodology in the proposed rule for determining the practice expense and malpractice RVUs. According to these comments, the proposed rule methodology is "seriously deficient" and "contrary to the intent of the statute" because it bases the practice expense and malpractice RVUs on 1991 average allowed charges, which incorporate legislatively mandated reductions in prevailing charges for overpriced procedures. An example was provided of a service with a \$100 average allowed charge in 1988 and a historic practice expense percentage of 50 percent. Basing the practice expense RVU on the 1989 average allowed charge using the proposed rule methodology would result in this service having a practice expense RVU of \$50 (before rescaling as described elsewhere). Assuming this procedure was overvalued by 30 percent, the target fee schedule amount would be \$70. If the legislation mandated payment reductions of \$10 in both 1990 and 1991, the 1991 average allowed charge would be \$80. Applying the historic practice expense percentage of 50 percent to the \$80 average allowed charge results in a practice expense RVU of \$40.

The commenters believe the practice expense RVU for this service should remain at \$50 because practice expenses have not declined as a result of the prevailing charge reductions. According to these commenters, the practice expense percentage should be 62.5 percent (\$50 divided by \$80) instead of 50 percent because practice costs now represent a greater proportion of the reduced average allowed charge. Some of these commenters also believe the converse argument would be true for services whose payments have increased since 1989. That is, the practice expense and malpractice RVUs overstate expenses because average charges have increased since 1989. Commenters suggested that we either

use charge data from an earlier year or make an explicit adjustment in the historic practice cost information to recognize that practice costs represent a higher proportion of the average allowed charge.

Other commenters disputed that the methodology in the proposed rule would result in the practice expense RVUs being too low. According to these commenters, basing the practice expense RVUs on 1991 charges results in RVUs that more closely approximate the resource-based value. These commenters also believe that physician practices may have become more efficient in response to payment reductions resulting in more appropriate valuation of the practice expense RVUs. These commenters stated that if the practice expense RVUs for services whose payments were reduced are increased, the result would be to reduce the "already minimal gains in payments for undervalued evaluation and management services." Finally, these commenters noted that section 6101 of Public Law 101-239 specifically requires us to use 1991 charge data to compute the practice expense RVUs.

Response: We believe the statute is clear on this issue. Section 1848(c)(2)(C) requires that the practice expense RVU equal the product of the following amounts:

- The base allowed charges (as defined in section 1848(c)(2)(D) for the service, and
- The practice expense percentage for the service (as determined under Section 1848(c)(3)(ii)).

Section 1848(c)(2)(D) defines "base allowed charge" as "the national average allowed charges for the service under this part for services furnished during 1991" (emphasis added). Section 1848(c)(3)(C)(ii) requires the Secretary to determine the practice expense percentage by multiplying the average percentage division of resources by physician specialty by the proportion of "such service * * * performed by physicians in that specialty." (The law also includes corresponding directions for determining the malpractice RVU.) To determine the average percentage allocation of resources by physician specialty, the Secretary is required by

section 1848(c)(3)(B) to use "national data that describe the elements of physician practice costs and revenues, by physician specialty." The statute does not specify or imply that these percentages are to be based on Medicare-derived revenue only. We believe the practice costs percentages are intended to reflect physicians' entire practice revenue.

As the law specifically requires the Secretary to use 1991 average allowed charges, we disagree with proposals to determine the practice expense and malpractice RVUs based on charge data from an earlier year. We also disagree that our methodology is "contrary to the intent" of the statute. Physician payment reform is intended to establish payment equity by redistributing payments from procedure-oriented specialties to primary care physicians. Because physician payment reform is budget neutral, increasing the practice costs components would have the effect of decreasing the work components, thus, redistributing payments from primary care physicians to procedure-oriented specialties. If Congress had intended payment equity to be established solely through the work RVU, the legislation could have specified that the practice and malpractice RVUs be based on 1989 average allowed charges.

In regard to the comment that we should have adjusted our 1989 practice costs percentages to reflect 1991 percentages, we did not make these adjustments. We believe it is unlikely that the practice expense percentages would have increased as illustrated in the above example. Practice costs are determined as a percentage of gross revenues. While the prevailing charge in the above example may have declined, there are other factors to consider. For example, it is widely accepted that service volumes increase steadily each year. This likely offsets some of the increase in practice costs percentages which would otherwise occur. Additionally, the practice costs percentages we used reflect revenues from all payers—not just Medicare. The payment reductions in the above example, however, reflect payment reductions for Medicare only. If physicians offset the losses due to the

prevailing charge reductions by raising prices or increasing volume for their non-Medicare patients, the loss of revenues would be less than implied by the amount of prevailing charge reduction. Again, this scenario would result in the practice costs percentage increasing less than in the example noted earlier.

Practice expenses for "overpriced procedures" under the charge-based methodology in the proposed rule are generally much higher than would be produced using PPRC's resource-based methodology, which attempts to measure the resources for practice costs per procedure. For example, in their 1991 Annual Report to Congress, the PPRC states that the practice expense payment under the PPRC's resource-based methodology would be reduced from \$1,428 to \$343 for 4-graft bypass surgery.

To determine the practice costs percentages we used 1989 data from the AMA's Socioeconomic Monitoring Survey—the latest year available. Thus, payment reductions in 1990 and 1991 would not be reflected in the practice costs data. We did not attempt to adjust these 1989 practice costs data to impute 1991 practice costs percentages because we had no strong evidence that the actual 1991 practice costs percentages would be significantly different from 1989 survey results. For example, there were Medicare payment reductions for cataract procedures in 1988; however, our review of 1987 through 1989 data from the AMA practice costs survey reveals only minor variations in practice costs percentages for ophthalmology between 1987 and 1989 (44.7 percent in 1987, 44.1 percent in 1988, and 44.4 percent in 1989). Although these data are limited and cannot be used to make definitive conclusions, they do not suggest a significant increase in the practice expense percentages as a result of overpriced procedure reductions. Once the actual 1991 practice costs data become available, we will reconsider this issue as part of our requirement to periodically review RVUs. For this final rule, we used the practice expense percentages in the table below.

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Physician Revenues, Net Income and Practice Expenses - 1989

11/13/91

AMA Specialty	HCFA Specialty	HCFA SPECIALTY CODE	As a % of Mean Total Revenue		
			MEAN NET INCOME	MEAN EXPENSES NET LIABILITY	MEAN LIABILITY EXPENSES
All Physicians			54.2%	41.0%	4.8%
General/Family Practice	Family Practice	08	43.9	52.2	3.9
	General Practice	01	43.9	52.2	3.9
Internal Medicine			50.8	46.4	2.8
General Internal Medicine	Internal Medicine	11	50.8	46.4	2.8
Cardiovascular Disease	Cardiovascular Disease	06	61.2	36.1	2.7
Other	Allergy	03	56.9	40.5	2.6
	Gastroenterology	10	56.9	40.5	2.6
	Geriatrics	38	56.9	40.5	2.6
	Nephrology	39	56.9	40.5	2.6
	Pulmonary Disease	29	56.9	40.5	2.6
Surgery			60.8	31.8	7.4
General Surgery	General Surgery	02	60.8	31.8	7.4
Otolaryngology	Otology, Laryngology, Rhinology	04	49.9	45.2	4.9
Orthopedic Surgery	Orthopedic Surgery	20	47.4	45.2	7.4
Ophthalmology	Ophthalmology	18	53.3	44.4	2.3
	Ophthalmology, Otology, Laryngology	17	53.3	44.4	2.3
Urological Surgery	Urology	34	56.2	39.9	3.9
Other	Hand Surgery	40	53.5	38.9	7.6
	Neurological Surgery	14	53.5	38.9	7.6
	Peripheral Vascular Disease or Surgery	23	53.5	38.9	7.6
	Plastic Surgery	24	53.5	38.9	7.6
	Proctology	28	53.5	38.9	7.6
	Thoracic Surgery	33	53.5	38.9	7.6
Pediatrics	Pediatrics	37	47.6	49.3	3.1
Obstetrics/Gynecology	Gynecology	09	53.2	38.0	8.8
	Obstetrics	15	53.2	38.0	8.8
	Obstetrics-Gynecology	16	53.2	38.0	8.8
Radiology*	Diagnostic X-Ray (Groups) 1\	71	46.2	50.5	3.3
	Global for the Below Radiology Specialties		59.8	37.2	3.0
	Radiation Therapy (Professional Component)	32	73.8	22.9	3.3
	Radiology (Professional Component)	30	73.8	22.9	3.3
	Roentgenology, Radiology (Professional Component)	31	73.8	22.9	3.3
	Radiation Therapy (Technical Component)	32	0.0	94.1	5.9
	Radiology (Technical Component)	30	0.0	94.1	5.9
	Roentgenology, Radiology (Technical Component)	31	0.0	94.1	5.9
Psychiatry	Psychiatry	26	69.9	26.4	3.7
	Psychiatry, Neurology	27	69.9	26.4	3.7
Anesthesiology	Anesthesiology	05	69.5	23.2	7.3
Pathology	Diagnostic Laboratory (Groups) 1\	72	46.2	50.5	3.3
	Pathologic Anatomy, clinical	21	69.6	28.5	1.9
	Pathology	22	69.6	28.5	1.9
Other Specialty					
Other	Dermatology	07	56.7	40.3	3.0
	Occupational Therapy (Groups) 1\	74	46.2	50.5	3.3
	Other Medical Care (Groups) 1\	75	46.2	50.5	3.3
	Neurology	13	56.7	40.3	3.0
	Nuclear Medicine	36	56.7	40.3	3.0
	Physical Medicine and Rehabilitation	25	56.7	40.3	3.0
No AMA Match	Clinic or Other Group Practice (Groups) 1\	70	46.2	50.5	3.3
No AMA Match	Oral Surgery 2\	19	40.9	54.7	4.4
No AMA Match	Optometrist 3\	41	47.0	52.9	0.1
No AMA Match	Podiatry 4\	48	48.0	47.8	4.2
No AMA Match	Chiropractor, Licensed 5\	35	39.8	58.4	1.8
No AMA Match 6\	Manipulative Therapy	12	54.2	41.0	4.8
	Miscellaneous	49	54.2	41.0	4.8
	Physical Therapy	65	54.2	41.0	4.8
	Occupational Therapist	67	54.2	41.0	4.8
	Physiotherapy	73	54.2	41.0	4.8

Source: American Medical Association, 1988-1990 Socioeconomic Monitoring System Core surveys except where indicated.

1\ Source: Medical Group Management Association, 1990 Cost and Survey Production Report

2\ Source: American Association of Oral and Maxillofacial Surgeons

3\ Source: American Optometry Association

4\ Source: American Podiatric Medical Association

5\ Source: American Chiropractic Association

6\ For these remaining specialties, we are using the practice cost percents from the AMA for all physicians.

*Note: For radiology services, the professional component percentages were based on data for radiologists with equipment expenses of \$5,000 or less. The technical component percentages were based on data for radiologists with equipment expenses of more than \$5,000.

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[Practice Costs Methodology]

Comment: Some commenters noted specific problems with the proposed practice costs methodology. According to these commenters, Harvard raised three specific comments. First, practice costs vary by specialty but data were gathered for an insufficient number of specialties. Second, the specialty-specific cost data were not evaluated or adequately validated. Third, the charge-based practice cost measurement does not adequately allocate practice costs between fixed and variable expenses.

Response: Section 1848 of the Act requires us to determine the average percentage allocation of resources among the work component, the practice expense component, and the malpractice expense component. These percentages must be based on national data that describe the elements of physician practice costs and revenues by physician specialty.

Given this statutory requirement, we used the best available data to determine practice expense percentages. We believe the practice expense data we used from the AMA's Socioeconomic Monitoring Report are the best available for the following reasons:

- The survey is the comprehensive single source of data on physician practice expenses.
- The survey is representative of physicians both geographically and across specialties.
- The survey is performed annually, includes a random sample of physicians each year, and with some minor exceptions, provides consistent data.
- The survey solicits information using a consistent set of questions for all specialties.

We know of no other single source of data that would be better to use for this purpose. Although we agree that the survey does not include discrete data for some subspecialties, responses of these subspecialties were included under the broader specialty categories. Consequently, we believe the responses of some of these specialties were included in the average practice cost shares. With regard to complaints that the practice expense data were not validated, we note that the practice costs shares have been fairly consistent from year to year across nearly all of the specialty categories. The results are generally consistent with results from surveys we have previously supported (for example, the 1984 Physician Practice Costs and Income Survey). With regard to complaints about the charge-based methodology, unless there is a legislative change, we are

statutorily obligated to use this charge based methodology.

In addition, we found that there were about 245 codes for which we had established work RVUs, but for which there was no historical data on which to base practice expense and malpractice expense RVUs. Many of these services are new codes in 1992 for which we have no reliable way of crosswalking data, but for which we have established work RVUs.

We calculated practice expense and malpractice expense RVUs for these services by imputing them from the work RVU for the service. We generally used the specialty percentages when we knew the specialty most likely to provide the service, and we used the all physician percentages when we were not sure of the specialty that would provide the service or when we believed several specialties may provide the service. For example, if a procedure has a work RVU of 6, and the specialty practice cost percentages for the specialty providing the service is 60 percent work, 30 percent practice expenses, and 10 percent malpractice, then the practice expense RVU would be 3 (that is, $30 \div 60 \times 6$), and the malpractice RVU would be 1 (that is, $10 \div 60 \times 6$).

We also used this methodology to set practice expense and malpractice RVUs for services with volumes so low that we lacked confidence in the charge data (generally procedures with national frequencies under 50). We believe that this is a valid means of setting these RVUs absent historic charge data and we expect to continue to impute use practice expense and malpractice expense RVUs for new services in the future using similar methods.

[Average Allowed Charges]

Comment: Some commenters opposed basing the practice expense RVUs on average allowed charges and believe that this approach is inconsistent with a resource-based methodology. These commenters acknowledge our legislative requirement to base the practice expense and malpractice RVUs on average allowed charges but believe that if we are committed to a resource-based methodology, we should request that Congress change the law. Other commenters urged us to publish a notice for comment of a resource-based methodology for determining practice costs. Still others acknowledge that it is infeasible to develop a resource-based methodology before January 1992 but urged us to state that the values will only be interim until we develop a more "appropriate system" of calculating practice and malpractice expenses.

Some commenters stated that we should implement a resource-based methodology in a budget neutral manner and that our methodology should incorporate different equipment and use volume considerations that do not compromise access to care in rural areas.

Response: We will be considering results of research and other proposed alternatives to the current charge-based practice costs methodology.

[Subspecialty Costs]

Comment: Some commenters stated the proposed rule methodology is unfair because the practice expense and malpractice RVUs will not recognize the higher costs of some subspecialties. They believe this is particularly a problem when the subspecialty is not distinctly recognized in the Medicare charge data. In the case of these subspecialties, their higher practice costs percentages are not included at all in the practice expense and malpractice RVU calculation. Some commenters either provided specific data or cited studies that they believe better reflect the practice costs for specific subspecialties. Other commenters believe we should recognize practice costs of each subspecialty to determine the practice expense RVUs if possible. If not, the practice expense RVUs should be recalculated when subspecialty data become available.

Response: To determine the practice expense and malpractice RVUs, we used practice costs data from the AMA's Socioeconomic Monitoring Report. As we stated above, we believe this report provides the best available data regarding practice expenses. Furthermore, we are reluctant to use data from uncoordinated and largely non-comparable sources to determine the practice expense RVUs for physician specialties because of our concerns about imparting bias that would be associated with using different survey instruments. Also, different surveys may not necessarily use a consistent set of questions to solicit information, and thus while benefitting one specialty, they could disadvantage other specialties. (For limited licensed, nonphysician practitioners, and group practices, the AMA had no data and, thus, we had to find another source of data. For these specialties only, we used survey information from their specialty societies.) As additional survey information that includes more detailed data on these specialties becomes available, we will consider making refinements in the practice costs RVUs.

[Specialty Visit Codes]

Comment: Other commenters raised a similar comment to the one described above in the context of visit codes. According to these commenters, family physicians have the highest practice costs percentage of the specialties listed in the proposed rule. These commenters noted that using the weighted average practice expense share for the visit codes will always result in a practice expense share that is less than the actual practice expense share for family physicians. According to these commenters this is more of a problem for the visit codes that are performed by a wide variety of specialties than other services that are more frequently performed by a single specialty.

Some commenters raised a similar comment to the one above in the context of malpractice. These commenters noted that the methodology will be unfair to gastroenterologists who have higher malpractice insurance than other internal medicine specialties but are listed in the category "internal medicine-other." Additionally, these commenters stated that malpractice premiums are determined by specialty regardless of how many procedures that physician performs. For instance, two gastroenterologists with the same loss experience, in the same geographic area, will pay similar premiums even if one performs three endoscopic procedures per day while the other performs only one per month. Because malpractice premiums are determined in this way, these commenters are skeptical that a procedure-specific malpractice RVU can be developed.

Some commenters raised other points related to the methodology for computing practice expense for visit codes. These commenters believe that practice expense and malpractice per unit of time should increase as the length of a visit increases. However, the practice expense and malpractice RVUs reveal decreasing practice expenses per unit of time as the length of a visit increases.

Response: The statute requires the practice expense RVUs to be determined as a weighted average of the practice expense shares for the specialties performing the service. We have determined the practice expense RVUs using this methodology. Again, as better data become available, we will consider making refinements to the practice expense RVUs.

[Rheumatology Practice Costs]

Comment: Some commenters cited a Harvard University study in the October 28, 1989 "Journal of the American

Medical Association" (JAMA) which found that practice costs for rheumatologists were "higher than any of the other medical specialties studied." These commenters requested that we use data from the above referenced study (adjusted to reflect 1991 practice costs) to determine practice expense percentages separately for rheumatology.

Response: As we stated earlier, the practice expense RVUs were determined as a weighted average of the practice expense shares for the specialties performing the service. However, as we have not recognized rheumatology as a distinct specialty, the Medicare charge data do not reflect the services furnished by rheumatologists. Therefore, even if we were to accept the practice costs data from the JAMA article cited above, we would have no way of determining which services were furnished by rheumatologists since the Medicare charge data would reflect their services under another specialty code. Further, to the extent that rheumatologists are included in the AMA survey, their practice cost percents are reflected in the category "Internal Medicine—Other."

[Inclusion of Allergists]

Comment: Some commenters stated that a survey by the Joint Council on Allergy and Immunology reveals that practice costs are 57.9 percent of revenues rather than the 40.5 percent we used in the proposed rule. According to these commenters, allergy should not be included with the "other" category of internal medicine. They stated that there are only 400 practicing allergists in the United States—about 1 percent of the total number of physicians. Because the AMA randomly surveys 4,000 physicians without regard to specialty, approximately 40 allergists can expect to be surveyed. Assuming a response of 60 percent, there would be 24 allergists responding. As the AMA does not report results for fewer than 50 respondents, by its very design, the AMA will not have specialty-specific survey data for allergists.

Response: Again, as stated above, although the AMA data do not include discrete data for allergy and immunology, the responses of allergists to the AMA survey would be included in the average practice cost shares for "Internal Medicine—Other." We also reiterate our concern about using practice costs data from multiple sources.

[Malpractice RVUs]

Comment: Some commenters noted that women of childbearing age eligible

for Medicare would be high risk obstetric patients because they often have a significant disability or end stage renal disease. These commenters believe that the methodology for determining the malpractice RVUs will not provide adequate compensation for providing high risk obstetric care.

Some commenters believe that many obstetricians are underinsured as they are not protected from claims that are made after a policy's expiration date. They suggested that this type of "tail coverage" is needed to protect physicians switching insurance companies, moving between states, restricting their practice or retiring. These commenters believe the Medicare payment system should accommodate the purchase of "tail coverage."

These commenters and others support one of the PPRC's approaches for paying malpractice expenses, which would have physicians submit evidence of their malpractice costs for a year and the percentage of their services provided to Medicare patients. Medicare would either pay insurance carriers directly or provide a lump sum payment to physicians for their malpractice costs.

Some commenters supported using a "risk of service" approach for determining malpractice expense. Under this method, the additional premiums of higher risk-class physicians are spread over the higher risk surgical services that are an integral part of their specialty.

Response: Again, we determined the malpractice RVUs using the methodology prescribed by the statute and we will consider making refinements in the future.

[Pathology Practice Expenses]

Comment: Some commenters stated that the 28.5 percent used to determine the practice expense RVU for pathology services was obtained from the Medical Group Management Association's 1990 Cost and Survey Production Report and that no attempt was made to differentiate between the practice expenses of independent laboratories and hospital-based pathologists. These commenters believe practice costs for independent laboratories are closer to 70 percent, a figure confirmed by a recently published Abt study.

Response: The 28.5 percent practice costs share was obtained from surveys of independently practicing pathologists and does not include independent laboratories. As independent laboratories are paid a technical component only, we discuss the Abt practice costs percentages in the

pathology technical component section of this preamble.

[Abt Survey]

Comment: Some commenters stated that an Abt survey of independently practicing pathologists reveals that 33.5 percent of gross revenues are attributable to practice costs rather than the 28.5 percent used in the proposed rule. These commenters believe the Abt survey more accurately reflects pathologists' practice costs because the survey was specifically designed for pathologists while the AMA survey is general to all specialties. For instance, the AMA survey asks questions about office expenses and non-physician payroll expenses while the Abt survey asks about "payments to a billing service."

Response: Again, we reiterate our earlier concerns about using data from multiple, uncoordinated, possibly non-comparable sources.

[Ophthalmology Survey]

Comment: Some commenters believe that a survey by the American Academy of Ophthalmology (AAO) reveals that 52 percent of gross revenues are attributable to practice costs rather than the 44.4 percent used in the proposed rule. According to these commenters, the AAO survey "represents geographic and subspecialty diversity among ophthalmologists, which probably was not possible in the AMA survey methodology." These commenters also stated that Medicare revenues for ophthalmologists declined due to overpriced procedure reductions and a reduction in the rate of growth in cataract surgery. As Medicare revenue can represent from 60 to 80 percent of an ophthalmologist's practice, the ratio of practice expense to revenues has increased since 1989, according to these commenters.

Response: With regard to AAO's survey, we reiterate our earlier comments. With regard to the ratio of practice expenses to revenues, we reiterate our earlier comments that we do not believe that this ratio has changed significantly. Also, overpriced procedure reductions for ophthalmology began in 1988, but the practice expense share in the AMA survey did not change significantly between 1987 and 1989 (44.7 percent in 1987, 44.1 percent in 1988, and 44.4 percent in 1989, respectively).

[Capital Costs]

Comment: Some commenters believe that Medicare should recognize the capital costs associated with furnishing certain procedures. For instance, these

commenters cited extracorporeal shock wave lithotripsy (ESWL) as an example of a service when a separate capital component should be recognized.

Response: We do recognize the higher capital costs of diagnostic procedures performed in the office through a technical component allowance. It is true that we do not have an equivalent technical component for therapeutic services performed in physicians' offices. However, Congress, through the ASC benefit, has provided a method for recognizing the costs, including capital costs, associated with performing surgical services outside of a hospital. Eventually, we expect to add ESWL to the approved ASC list of procedures. Additionally, as noted in the discussion of site of service differentials, practice costs for procedures routinely performed in the office are based solely on charges in the office setting. Therefore, the expenses of performing procedures associated with high cost equipment are recognized to the extent that higher costs are reflected in the charge data.

[Malpractice Premiums for Interventional Radiologists]

Comment: Some commenters stated that interventional radiologists pay higher malpractice premiums than other radiologists. According to these commenters, because we based malpractice on the practice costs percentages for non-interventional radiologists, interventional radiologists would be undercompensated for malpractice expenses. These commenters acknowledged the limited detail of the data but requested that we establish interventional radiology as a physician specialty and that we recalculate the malpractice RVUs only for interventional radiologists as data becomes available.

Response: The practice expense data from the AMA did not distinguish between radiology and interventional radiology. Furthermore, interventional radiology is not separately identified as a distinct specialty in the Medicare charge data. Consequently, we were unable to separately reflect the practice costs shares of interventional radiologists. However, while we do not expect to establish interventional radiology as a separate physician specialty for data reporting purposes, we would consider future refinements in the practice expense RVUs if adequate specific practice cost information for this subspecialty becomes available.

8. Combining Work, Practice Expense, and Malpractice RVUs onto a Common Scale

The work RVU was initially scaled in units selected by the Harvard study, whereas the practice expense and malpractice RVUs were initially computed in dollar units. In the proposed rule, we chose to convert Harvard work RVUs to dollar units and then to rescale all RVUs relative to the new Level 3 established office visit (for which total RVUs will equal 1).

Comment: Some commenters objected to our use of the Level 3 established office visit as the base for the RVS. They stated that rescaling the RVUs on this base greatly complicated evaluation of the relative values provided in the proposed rule, since they are on a different scale than that presented by the Harvard research team in the Phase II report. The commenters stated that the rescaling made it far more difficult to evaluate whether we changed the proposed rule RVUs from those presented in the Harvard research team's Phase II report, and whether these changes were due to refinements in Phase III of the Harvard study, typographical errors in RVUs, or other factors. The commenters stated that in future publications of the RVUs, we should publish RVUs on the same scale as that used by the Harvard research team.

Some commenters also stated that the mid-level office visit cannot be considered to be a consistent standard between physician specialty groups. They believe it is unreasonable to assume that since an intermediate office visit is the one most often billed to Medicare, the service is the same for all physicians.

Commenters also stated that the methodology for rescaling the Harvard values into a dollar scale may have resulted in value reductions, similar to rounding down to the nearest dollar.

Response: We have continued to use the Level 3 office visit as the basis for the RVS because we believe that this service is one of the few services that is meaningful to most physician specialties. Virtually every Medicare specialty bills for office visits.

In addition, the selection of a service as the base for the RVS is an arbitrary choice since the relative placement of the values on the scale is not changed by the selection of the base service. Moreover, the RVUs for practice expense and malpractice expense are charge-based and had to be placed on a common scale with the work RVUs. Reductions in relative values that occur

as a result of the rescaling are offset by a corresponding increase in the budget-neutral CF. Lastly, we believe there is no compelling reason to use the Harvard scale since not all of the physician work RVUs were products of the Harvard study. To convert the work RVUs in Addendum B to the Harvard Phase II scale, the work RVU must be multiplied by 94.216.

9. Periodic Review and Adjustments in RVUs

a. *Proposed policy for review and adjustments.* In § 415.24(a), we proposed to announce RVUs for new services and changes in RVUs already in effect by publishing a proposed notice in the **Federal Register** with an opportunity for public comment no less often than every 5 years. After reviewing the public comments, we would publish a final notice in the **Federal Register** to announce additions or revisions to RVUs.

In § 415.24(b), we proposed that we would, as needed, establish interim RVUs for new services or recognize changes in definitions of codes for services.

We proposed to change RVUs (standing/new/revised) through publication of proposed and final notices in the **Federal Register** but to provide an "interim value" process that would allow us to quickly implement national RVUs for new/revised codes (§ 415.24(a)). No retroactive changes in RVU values or payment amounts would be made; changes from interim to final values would be made prospectively.

We explained in the proposed rule (56 FR 25814) that the "interim value" process would be likely to result in interim values being added to the physician fee schedule each year because the CPT revises and deletes some codes each year. The AMA has proposed that the CPT process be expanded to produce recommendations regarding RVUs for newly coded services, RVUs for services with revised codes, and changes to standing RVUs.

We proposed to carefully consider recommendations from the CPT process regarding new or revised codes with advice, if necessary, from CMDs or other expert advisers, before we would use them as interim values. Moreover, we explained that even if the AMA process were used, it would not constitute the exclusive means for us to receive advice and recommendations on new or revised values. Specialty societies or other groups would, of course, be free to submit their recommendations directly to us and we would carefully consider them. Finally, these interim values would be included

in the proposed and final **Federal Register** notices before they could become standing RVUs. Changes to standing RVUs would only be implemented through publication of the proposed and final **Federal Register** notices.

[Process for Establishing RVUs for New Procedures and for Revising Existing RVUs]

Comment: We received many comments regarding the process for creating RVUs for new and revised codes and the review of RVUs for existing codes, and comments representing widely diverging points of view on which process should be adopted. Some commenters supported the AMA's proposal to develop RVUs for new services and recommend refinements to existing RVUs as being an appropriate way for acquiring professional input into the work RVU refinement process. Other commenters supported the use of the AMA to develop RVUs for new services and proposed revision to RVUs but only if we would agree that an organization that objected to the AMA-developed values would be allowed to present its position to us.

Other commenters stated that if the AMA process is used to establish or review RVUs, there should be a written policy on the methods to be used to change work RVUs that are based on the original Harvard methodology, that it should be composed of physicians only, and that it should be at least 50 percent primary care (preferably family practice) physicians because the history of the CPT process is that primary care physicians have been under-represented and that the subspecialties have had undue influence on the CPT codes established.

Other commenters stated that if the AMA RVU development and refinement process were not to include physicians other than MDs or DOs, we should create a technical advisory group containing representatives of all specialties to create or refine work RVUs.

Some commenters suggested that we specify in regulations that, in the review of RVUs for new services and changes in existing RVUs, we would consider the recommendations from representatives of physicians who furnish medical care services.

Some commenters suggested that we establish a procedure for developing and reviewing work RVUs by small groups of physicians who perform the services. They indicated that this is the only way for us to get RVUs for new services that originate among small numbers of

specialists before they expand to be generally accepted procedures.

Other commenters stated that we should create a technical advisory group made up of our staff, carrier representatives, and representatives of physician organizations that would establish the RVUs for new services and review RVUs for existing services. Other commenters objected to the use of physician organizations to establish or revise RVUs for physician work. They stated that the establishment of the work RVUs should be a government process and that the participation of physician-directed organizations should be limited to bringing new advances and discrepancies in RVUs to our attention for impartial adjudication.

Response: While we have not fully specified the process we will use, we may have our staff physicians review the new codes, review recommendations for RVUs for new services, review recommendations for changes to RVUs for current services, and consult with appropriate specialists. We may also utilize the CMDs to review the same issues. We will make recommendations to the Secretary for approval regarding interim values for new or revised services.

As indicated in section I (Summary of this Final Rule), we consider the work values in addendum B to be "initial" values for which we will accept public comments. We are providing a 120-day comment period on these "initial" values. Any changes in response to comments will be finalized in a final notice published in the **Federal Register**, and will go into effect on January 1, 1993.

We are convinced that a consensus or Delphi process such as the one we used with the CMDs can serve as a valuable tool for the purpose of future refinement of the RVUs. We also see a consensus process as a tool that a specialty society or an umbrella organization such as the American College of Surgeons could use to recommend further "fine tuning" of the scale. We see this as particularly applicable for services under that specialty's aegis and not as a way of dealing with inter-specialty scaling issues. We particularly welcome comments regarding adjustments to the RVUs for procedures within a specialty that keep the total RVU "pool" constant for these procedures.

[Annual Review]

Comment: Commenters indicated that during the initial implementation phase for the new RVUs it would be more appropriate to conduct an annual review, but that after 5 years of

experience, it may be possible to move toward biennial review and after 10 years to conduct review once every 5 years.

Response: We will consider this comment further as we review RVUs in the future. We expect continuing advances in medical care due to new technology and changes in medical practice. Therefore, we will review the RVUs for all services on an ongoing basis in order to keep the system as current as possible.

[Mechanism for Revising RVUs to Reflect Changes in Technology]

Comment: Commenters stated that it is particularly important for us to develop a mechanism for dealing with changes in technology and surgical practices that are not reflected in the CPT codes. They indicate that the CPT process sometimes does not deal efficiently with changes in technology, or surgical advancements, and that commonly performed procedures or common variations of procedures would then be absent from the CPT RVU development process and payment may be left to carrier discretion rather than included in the national fee schedule.

Response: We have the capacity to establish codes if we are convinced that there should be a new code for a physician service or if a service represents a change in a technology or a change in surgical practice, and the CPT Editorial Panel fails to establish a code. We are confident that the physician organizations that bring these cases to our attention will continue to do so and that they will provide cost information regarding the service or changes in the service on which we could make a decision about their relative values.

b. *Implementation of the \$20 million limitation.* Section 1848(c)(2)(B)(ii)(II) of the Act requires that adjustments to RVUs that are made as a result of changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures may not cause the amount of expenditures under Part B for the year to differ by more than \$20 million from the expenditures that would have been paid had the adjustments not been made. Therefore, the adjustments must be essentially budget neutral (within a \$20 million tolerance per year), based on the expected expenditures for the year.

[Annual Updates]

Comment: Commenters objected to our proposal to exclude only "totally new" services from the \$20 million limitation associated with annual updates to the RVS to reflect changes in medical practice and coding, new data

on relative values, or the addition of new procedures. The commenters believe that taking this narrow reading of the limit runs a substantial risk of imposing, via this minor provision, a de facto expenditure cap on Medicare's payment for physician services. Commenters stated that the reading of this provision of the statute is particularly troubling given our proposal to use the annual update process to meet the statutory requirement for full review of the RVS at least once every 5 years. They believe that our reading of the \$20 million provision and the annual review of RVUs may impose a "chilling" effect on consideration of legitimate changes on physician work, practice expense, and malpractice RVUs. The commenters stated that we need to develop a far more sophisticated and detailed method of implementing the \$20 million limit so that fundamental advancements in medical practice are not impeded. Some commenters indicated that the intent of the provision was to prevent us from using the reduction of RVUs as a means of obtaining Medicare budget savings.

Response: We will carefully consider this comment as we do future updates of the RVS. It is certainly not our intention to use the \$20 million limitation on RVS adjustment to achieve budget savings or to impede the advancement of medical practice.

D. Geographic Adjustment Factors (GAFs)

The statute specifies that the total RVUs for a service must be adjusted by the GAF. The GAF is equal to a weighted average of the individual adjustment factors or GPCIs for each of the three RVU components—work; practice expense (exclusive of malpractice), referred to throughout this rule simply as "practice expense"; and malpractice.

Section 1848(e) of the Act requires the Secretary to develop GAFs for all physician fee schedule areas. It requires an index to reflect the relative cost of practice expenses compared to the national average; an index to reflect the relative cost of malpractice compared to the national average; and an index to reflect one-quarter of the relative cost of physicians' work compared to the national average. The law does not specify the methodology to be used in developing these GPCIs; instead, it leaves the methodology to the discretion of the Secretary.

Components of a GAF were already under development as a result of Public Law 99-509, which required the Secretary to develop an index by December 31, 1989 to measure

"justifiable" geographic differences in physicians' costs of furnishing services. As a result of this provision, alternative GPCIs were developed by the joint efforts of the UI/CHER. See addendum D of the proposed rule (56 FR 25974) for information regarding how to obtain copies of their reports.

A list of the GPCIs for all current Medicare localities in the form required by section 1848(e) of the Act was published in the proposed rule at addendum C (56 FR 25966). The proposed rule explained that the GAF to be used in the physician fee schedule is based on the research performed by UI/CHER. We stated in the proposed rule that the studies of the GPCIs being conducted by us and the PPRC may result in future changes in the GPCIs. However, the GPCIs in this final rule, which will go into effect January 1, 1992, differ only slightly from those in the proposed rule. The minor changes made are described in addendum C to this final rule.

[Age of Data]

Comment: Many commenters stated that the GPCIs are based on 1980 census data and other old data and are not a true reflection of current differences among areas in resource costs. For example, one commenter stated that the comparisons show that geographic differences in the price of inputs remain even after accounting for the GPIC. All commenters urge that we develop more current and better data sources.

Response: As explained in the proposed rule, the data on rents are fairly recent (1987). The data on physician work and employee wages are from the 1980 census and will not be updated until 1990 census data are available, probably sometime in 1993. While the census data are 10 years old, the GPCIs have been examined by groups both inside and outside of the government, such as the PPRC, and have been found to be generally accurate and the best available measurement of the relative differences among areas in medical practice costs. We have begun the process of acquiring 1990 census data, more recent rental data, and a survey of malpractice insurers is in progress.

[Use of Recent Malpractice Data by Area]

Comment: Some commenters asked why we did not use the latest available data on malpractice insurance premiums from each area for the malpractice GPIC.

Response: We have entered into a cooperative agreement with the UI to

attempt to gather 1988 through 1990 premium data from the major malpractice insurers in each State. We anticipate that this effort will be completed by the end of this year. Past studies have shown that malpractice premiums are often volatile from one year to the next. For instance, the Liability Expense category for the Medicare Economic Index rose at double-digit annual rates each year from 1985 to 1989; then this growth declined to less than 1 percent for 1990 and may be negative for 1991. To counter this volatility, the initial malpractice GPCI used 2 years of data from each locality. While several medical organizations, including the medical societies of Massachusetts, the District of Columbia, and Rhode Island provided some malpractice insurance premium information with their comments on the proposed rule, none of these submissions was adequate for recalculating the malpractice GPCIs. The most complete set of data covered only 40 States, but missed key States such as Florida, New Jersey, and Maryland. We are confident that an alternative malpractice GPCI can be constructed for future use in the fee schedule. However, we also anticipate that the volatility problem will not be easily eliminated.

[Accuracy of GPCI for Urban Areas]

Comment: Commenters stated that the GPCIs do not adequately recognize the higher costs of practice in urban areas like Manhattan, San Francisco, and Chicago. Costs in these areas are much higher than the national average.

Response: The GPCIs do not reflect all of the cost differences in high cost—usually urban—fee schedule areas. While the law allows for full recognition of practice expense and malpractice expense differences, it allows for recognition of only one-quarter of the cost difference in physician work, generally the largest of the three components. Aside from this, the GPCIs have been examined by groups both inside and outside of the Federal government and have been found to be the best available measurement of the relative differences among areas in medical practice costs.

[Rural Area Practice Costs]

Comment: Some physicians in rural areas commented that their practice costs are not lower than in urban areas. They stated that some of their costs may be higher because of higher shipping costs for equipment and supplies, added travel costs for continuing education, higher payments to attract qualified help, and the expense of large sums to

build their own office space when adequate rental space is not available. They recommended that payments not vary by geographic area.

Response: We cannot pay all physicians the same under the physician fee schedule. The law requires that payments vary among areas to the extent that practice costs vary as measured by the GPCIs. The GPCIs show that, in general, practice costs are higher in urban than in rural areas, and we have not been presented with any convincing evidence to the contrary.

[Uniform Payment Amounts]

Comment: Some commenters believe there should be one fee schedule rate in the country since there is a uniform premium and deductible. Some commenters believe that practice costs do not vary by geographic area.

Response: The law requires that fee schedule payments vary according to the relative differences among areas compared to the national average in the resource costs of furnishing the services. The statute does not contemplate Medicare having a nationally uniform schedule of payments for all physician services.

The law provides that all three components—physician work, practice expense, and malpractice expense—of the fee schedule must vary as measured by the GPCI. However, while the law provides for the full variation in practice expense and malpractice expense, it provides for only one-quarter of the variation in work. This has the effect of distributing payments from high-cost, usually urban, to lower-cost, usually rural, areas.

[GPCI Should Reflect Individual Practice Costs]

Comment: Some commenters noted that their particular location within the fee schedule area has much higher rents and overall higher costs of living than the rest of the area. The commenters stated that the area GPCI is therefore inadequate to reflect costs, and they should be given a GPCI that reflects individual costs.

Response: The GPCI is intended to reflect the relative costs of inputs within a fee schedule area compared to the national average. Costs in a particular location within the area or costs for an individual physician may vary significantly from the general costs in the area. Decisions to locate in a particularly high rent district, to pay high salaries, to purchase expensive equipment, or to practice inefficiently are presumably business decisions made in each individual case. The GPCIs were not intended to be

physician-specific or to guarantee an individual physician a specific return on investment.

[Use of Proxy Data]

Comment: Many commenters objected to the use of proxies in developing the GPCI. They stated that we should acquire data on actual physician input prices and rely less on proxies. One commenter stated that using proxies with lower absolute values than the actual inputs—wages of teachers and engineers for physician work and apartment rents for physician office rents—was done intentionally to lower overall payments to physicians. Another commenter stated that data on physician rent were readily available in his community from a local government agency.

Response: We would have used actual cost data on physician inputs had this data been widely and consistently available. The purpose of the GPCI is to measure "relative" differences in the costs of physician inputs among fee schedule areas. To do this, data must be used that is readily available and calculated consistently across all areas. While physician rent data may be available from a particular local source in one area, comparable data may not be available in other areas. The census and the Department of Housing and Urban Development (HUD) data were used because they were widely and consistently available. We have not yet found a consistent source of data on local commercial rent charges.

Using proxies with lower absolute values than physician inputs was not done to lower overall physician payment levels. The GPCIs have absolutely no effect on overall outlay levels. The same total payments are used under the fee schedule as would have been paid under the present system. The relative values redistribute the money among procedures. The GPCIs merely redistribute the money among areas. While teachers may have lower earnings than physicians and apartment rents may be lower than physician office rent, it is the relative differences among areas in these inputs that are measured by the GPCIs. Our method assumes that, in most areas, physician earnings' levels will have a similar relationship to earnings' levels of other highly educated professionals, and that commercial office rent levels will have a similar relationship with residential rent levels. We further believe it would not be good policy to adjust physician payments by an expenditures index. This policy would reward profligate spending while

penalizing efficiency. We will, however, continue to analyze alternative data sources for all components of the GPCI.

[Medical Equipment and Supply Costs]

Comment: Some commenters stated that it cannot be correctly assumed that the costs of medical equipment and supplies do not vary appreciably among areas. Areas like Alaska and Hawaii have higher shipping costs. Some commenters stated that costs are higher in rural areas because of the lack of a competitive market. Others stated that costs are higher in very large high-cost urban areas.

Response: There was a lack of proxy data for medical equipment and supplies. Since equipment and supplies can generally be ordered from national suppliers, a national market was assumed. As with the other proxies, we will be searching for better data to update the GPCI.

[Family Physicians in Rural Areas]

Comment: Some commenters noted that a higher proportion of family physicians practice in rural areas. These physicians tend to furnish mostly visit services. It was suggested that the visit practice expense component of family physicians is undervalued in the fee schedule. When these factors are combined with the fact that practice expense GPCIs are lower in rural areas, it was suggested that fee schedule payments for visits in rural areas would be treated inequitably. To correct this situation, commenters believe that we should establish a separate class-specific practice expense GPCI for visit services as authorized under section 1848(e)(1)(B) of the Act.

Response: We will consider this suggestion if we are presented with data to substantiate a claim that a particular GPCI produces an inequitable result. The intent of the comment is to increase payment in rural areas. We are not sure that a separate practice expense GPCI for visit services will do this. The GPCI will apply to the class of services across all areas, urban as well as rural. The situation may be better addressed by examining whether the practice expense cost shares, which are set through a statutory formula, should be revised for visits.

[Malpractice Premiums]

Comment: Some commenters noted that the proposed rule does not state whether the malpractice GPCIs were based on the premiums for the first or the fifth year of a claims made policy, or whether the cost of protecting physicians against malpractice claims made years after caring for a patient

(referred to as "tail coverage") was included. They believe that these factors could greatly affect the malpractice GPCI.

Response: The malpractice GPCIs were based on the premium for a mature claims made policy. We considered but made no adjustment for "tail coverage". We believe that tail coverage is implicitly accounted for in our use of a Medicare weighted risk-group premium. Not all physicians need or buy this coverage. Most policies have a right to purchase tail coverage, but there is no contractual obligation to buy it if the physician believes it is not necessary. Furthermore, some companies provide tail coverage at no cost automatically in the event of death or permanent and total disability before age 65. Similarly, some policies have built into the premium such coverage for physicians who die or retire after age 65 and who have been insured by the specific company for at least 5 consecutive years immediately before the event. Hence full tail coverage is provided at no additional cost. For all these reasons, we do not believe an explicit adjustment is required at this time, but we could reconsider an adjustment in future revisions of the malpractice GPCI.

[GPCI for Manhattan, New York]

Comment: Some commenters believe that the GPCI for Manhattan, New York does not recognize the high rents there. They believe this GPCI is erroneous because the rent proxy from Bergen-Passaic, New Jersey was used rather than the rents in Manhattan.

Response: The GPCIs for all localities were developed from data based on an MSA and non-MSA basis. However, the HUD rent data for the New York City MSA was unrealistically low because of rent control. Therefore, we used the highest rent proxy in the New York City consolidated MSA, which is for Bergen-Passaic, New Jersey. This is one of the highest rent indices in the country (about 60 percent above the national average). Using this proxy, therefore, is advantageous for Manhattan in comparison to using the unrealistically low values reflecting rent control.

[GPCI Inaccurate Compared to Neighboring Area]

Comment: Commenters in some areas—the Iowa Quad cities, for example—stated that practice costs in their area are just as high as some of the commenters' colleagues in the neighboring fee schedule area—such as the Illinois Quad cities—yet the GPCI is lower. The commenter believes that the GPCI should be as high as that in the neighboring area.

Response: The GPCIs are intended to measure the general differences among Medicare payment areas compared to the national average in input costs. The statute indicates that relative values must be developed for each Medicare payment locality and that these localities must be those used in establishing the historic payment base, which would mean the current localities or aggregations of them. Thus, the GPCIs must measure cost differences between the Medicare payment localities. While we believe the GPCIs to be the best available measure of these differences, it is possible that a particular physician or group of physicians may have costs that are not in line with those reflected by the GPCI. The GPCI, however, is not designed to reflect the costs of each individual physician.

[Update of Census Data]

Comment: One commenter believes that we should not wait until 1994 to update the GPCI because census data will not be available until 1993. The GPCIs should be updated as soon as better data are available.

Response: We will consider updating the GPCI as soon as better objective and supportable data are available. We believe obtaining the results from the 1990 Census, which will include earnings data for 1989 for a 20 percent sample of all respondents, will be essential for a complete update of the GPCIs.

[Use of Hospital Wage Index or Commercial Rent Data]

Comment: Several commenters questioned why we used the 1980 Census and 1987 HUD Housing Rental data instead of the HCFA hospital wage index or commercial rent information sources.

Response: The purpose of the GAF or GPCIs is to recognize "justifiable differences in the costs of operating a medical practice" in different areas. Medicare uses some 240 localities for determining physician payment rates. Hence, measures were needed that covered as many areas as were possible. The two largest components of the GAF are physician's own time (net income) and employee wages. No source other than the 1980 Census' 20 percent sample gave adequate and balanced coverage for earnings in all 240 payment areas. Census data also permitted us to standardize the earnings data for geographic differences in job-mix.

We believe physician earnings will vary geographically in about the same way as the earnings of other highly educated persons. We know that the

mix of employees in physician practices differs from the employee mix of hospitals. We could identify no source of rental costs that covered more distinct areas than the HUD housing rental source.

We believe it would not be wise to adjust the GAFs annually, because many of the changes from year 1 to year 2 would be reversed in year 3. (We have already observed this in the aforementioned hospital wage index.) We intend to revise the GAFs at least every 3 years as is required by Public Law 101-508. In the next revision, we contemplate using available results from the 1990 Census for the 2 major practice cost components, physician time and employee wages. We are already collecting later and more complete data for revising the malpractice expense GPCI.

[Misunderstandings About GPICs, GAFs, and the MEI]

Comment: Some commenters conveyed misunderstandings about the difference between the GPCI or GAFs and the MEI, or between the GPICs and the relative value components.

Response: The GPCI or GAF aims to reflect the justifiable differences in practice level costs of doctors between one area and another. It was calculated by using the same expense categories, to the extent feasible, as are used in the MEI. Like the MEI, it used recent AMA data to derive share-weights for the various cost components. The MEI aims to measure changes in the costs of resources used in operating a medical practice overtime. The MEI is an estimate for the nation, while the GPICs estimate how a particular area's costs compare with the national average. By statute, the MEI is updated annually, while the GPCI must be updated at least every 3 years.

The relative value for each procedure in the fee schedule has 3 components—work, practice expense, and malpractice. A separate GPCI has been estimated for adjusting each of these components for locality cost level differences. The work components were nearly all from the results of the Harvard study. The practice expense and malpractice components were calculated using estimated 1991 average allowed charges and the AMA data on the 1989 practice expense/gross revenue and malpractice expense/gross revenue percentages of the specialties that perform each procedure weighted by the specialties' share of the Medicare frequency for that procedure. The GPICs for the practice expense and malpractice components portray the full difference found in these costs, while the work

GPCI, by statute, is one-fourth of the full difference.

[Massachusetts GPCI]

Comment: Some commenters from Massachusetts contend that their malpractice GPCI should be 37 percent higher, and their practice expense GPCI should be 5 percent higher than what we proposed. They provided reports from an actuarial firm, Milliman and Robertson, Inc., and results of a study done by the American Medical Association Center for Health Policy Research to support these contentions.

Response: The main basis for their malpractice GPCI complaint is that the Massachusetts value does not reflect a surcharge that most Massachusetts physicians have paid since 1987. We agree that including this factor would raise the Massachusetts malpractice GPCI value by about 33 percent and slightly lower the values for all other areas. We will not make this adjustment at this time, however, because it did not apply during the 1985/1986 base years used to compute all malpractice GPICs. It would be inequitable not to use the same data base for all areas. We will consider this when the GPCI is updated and are already collecting later and more comprehensive data for this purpose.

The practice expense GPCI comments are based on (1) an AMA study which suggests that there is regional variation in equipment and other expenses which the GPCI does not reflect, and (2) some analyses using the HCFA hospital wage index for the employee wage component and a derivative of it for the rent component. A number of alternatives were considered before choosing the proxies for these factors, including the HCFA hospital wage index. Data such as those used by Milliman and Robertson were considered in constructing the GPICs. Census and HUD data were used because they were the best data readily available in all Medicare localities. The 5 percent difference in values that would result from using the method suggested by Massachusetts is simply a result that arises from the use of different methods and measures than those we used.

[Puerto Rico GPCI]

Comment: Some commenters from Puerto Rico Medical Society (PRMS) have stated that their GPCI values were too low.

Response: After publication of the model fee schedule, a meeting was held with representatives from Puerto Rico to discuss the matter. At the meeting, they agreed that there were no better data available than those which were used

and that the methods used were appropriate. Their consultant stated that the low wages found in Puerto Rico relate to high structural unemployment. They also stated they were disadvantaged by not including measures of geographic differences in medical equipment costs. They were invited to provide data concerning the extra costs they pay for importing much of their medical equipment. To our knowledge, no data were ever supplied. At that time, we also intend to use the results of the 1990 Census and more recent data for the rent proxy and for the malpractice expense GPCI.

[District of Columbia GPCI]

Comment: Some commenters from the District of Columbia stated that its malpractice expense GPCI is too low, as are the values for the wage and rent components of the practice expense GPCI. As evidence for their comment on the malpractice GPCI, they included 1990 premium data for mature claims-made policies for orthopedic surgeons and first year and mature claims-made premiums for obstetrician/gynecologists in the District versus those in the Maryland and Virginia suburbs.

Response: It apparently was unclear to the society that in the re-mapping done for the proposed rule, we decided to use only the District of Columbia premiums to calculate the value for the DC locality. They also stated that practice expense costs in DC for "everything from salaries to rent to workman's compensation to unemployment insurance are 20 to 30 percent higher" than in surrounding jurisdictions. But, one can observe from the summary of GPICs by State that the practice expense GPCI for DC is second only to Alaska's and is higher than both Maryland's and Virginia's practice expense GPCI.

[New Hampshire GPCI]

Comment: Some commenters from New Hampshire stated its malpractice GPCI should be higher than that for Massachusetts because "malpractice premiums are approximately one-third higher than those in Massachusetts". They also stated "careful cost of living analysis reveals that New Hampshire is in the 91st percentile in the country for cost of living, yet the GPCI does not reflect this."

Response: No data were supplied to support this position.

[Rhode Island GPCI]

Comment: Some commenters from Rhode Island stated its malpractice GPCI is too low. They claim to have

been in the top 20 percent of States throughout the 1980s and submitted information on 1990 rates for Risk Class 4 in more than 30 States. The Rhode Island premium ranks 9th. They also argue that the weighting methods used in the malpractice GPCI are unfair to smaller States, and that an unweighted index should have been used instead. They conclude by stating that their malpractice GPCI should be "well above 1.0". Commenters also stated that their practice expense GPCI is too low and provided examples from a HUD listing of urban rental values for 43 cities, in which Providence ranks 14th. They also provide data on hospital vacancy rates for selected positions in the U.S., New England, and Rhode Island, and minimum and average hospital wage information for Rhode Island, Connecticut, Massachusetts, and Boston (which usually show Rhode Island to be the lowest of the 4).

Response: We do not have, and the commenters did not supply, adequate data to permit us to evaluate their concerns.

E. Conversion Factor (CF)

1. Overview of Computation of Budget-Neutral CF

Under the statute, the general formula for a payment amount under the fee schedule multiplies a relative value for a service by a GAF for a fee schedule area by a CF. Thus the CF can be viewed as a multiplier that transforms relative values into payment amounts. The CF is a single national value that must apply to all services paid under the fee schedule (except that different CFs for surgical and nonsurgical services may eventually result from differential updates under the MVPS). Section 1848(d)(1)(B) of the Act specifies the methodology for setting the CF for the first year of the fee schedule (1992). A base year CF must be computed that is budget neutral relative to 1991 predicted expenditure levels. That is, this base CF must produce total payments under the fee schedule that are the same as total payments that are expected in 1991 under the current payment rules (generally based on the customary, prevailing, and reasonable charge methodology). The CF for 1992 must be established by updating this base year CF by the annual update factor.

Beginning in CY 1991, section 1848(d)(2) of the Act requires the Secretary to recommend to Congress by April 15 of each year an update to the fee schedule CF for the following CY. Congress may choose to enact the Secretary's recommendation, enact some other update amount, or not act at

all. If Congress does not act, the annual update is set according to a "default" mechanism in the law. The law states that the update must equal the "appropriate update index" adjusted by the amount actual expenditures for the first FY preceding the recommendations were greater or less than the performance standard rate of increase for that FY (also referred to as the "performance adjustment").

Under the default mechanism, the update equals the MEI plus or minus the performance adjustment. As Congress has not enacted an update for 1992, we are determining the update using the default mechanism. Our most recent estimate of the MEI for CY 1992 is 3.2 percent. However, section 4105 of Public Law 101-508 requires that this estimate be reduced by .4 percentage points. The performance standard rate of increase for FY 1990 was 9.1 percent. Expenditures between FY 1989 and FY 1990 increased by 10.0 percent or 0.9 percentage points more than the performance standard rate of increase. Consequently, subtracting the performance adjustment of 0.9 percentage points from the MEI of 2.8 percent (as adjusted by Public Law 101-508) yields an update of 1.9 percent.

Section 1848(d)(1)(C) of the Act requires the Secretary to publish the initial CF and the update for 1992. Later in this preamble, we have provided our estimate of the initial CF in compliance with section 1848(d)(1)(C). We are publishing the 1992 update of 1.9 in a separate notice in the *Federal Register*. This will be the update for 1992 in the absence of Congressional action to set the update.

2. Accounting for Transition Payment Rules in CF Calculation

Under the transition rules, as set forth in section 1848(a)(2) of the Act, the fee schedule will be phased in from CYs 1992 through 1995. The phase-in will begin with computation of an AHPB or amount for each service in each fee schedule area. For non-radiology services, this is defined in section 1848(a)(2)(D)(i) of the Act as the weighted average prevailing charge in the area in CY 1991 with consideration of customary charges below the prevailing and other payment limitations, adjusted by the annual update applicable to CY 1992 payments. (Computation of this update amount is detailed at the end of this CF discussion.) Under the law, a separate AHPB must be calculated for each procedure in each fee schedule area. We proposed that services from July 1, 1989 through June 30, 1990 will be used as the base for calculating the AHPB. Under

the statutory transition rules, if the historical payment amount for a service in a fee schedule area is from 85 to 115 percent of the fee schedule amount, maximum payment to all physicians in the fee schedule area would be at the fee schedule amount in CY 1992. However, if the historical payment amount is below 85 percent of the fee schedule amount, the payment amount for the service would be the historical payment amount plus 15 percent of the fee schedule amount. On the other hand, if the historical payment amount is more than 115 percent of the fee schedule amount, the payment amount for CY 1992 would be the historical payment amount minus 15 percent of the fee schedule amount.

Under section 1848(a)(2)(C) of the Act, as amended by section 4102(b) of Public Law 101-508, special transition rules would apply to radiology services in CY 1992. For those services, whether or not they were included in the radiologist fee schedule, the transition provisions limiting reductions in payment amounts would apply if the historical payment amount exceeds 109 percent of the fee schedule amount, rather than the 115 percent applicable to other services. For those radiology services subject to reduction under the transition rules, the amount payable would be equal to the historical payment amount minus 9 percent (rather than 15 percent) of the fee schedule amount for the service. Otherwise, the transition rules governing increases and decreases in payment amounts for radiology services would be the same as for other services. In addition, we proposed to establish special transition rules for the new CPT visit and consultation codes. Special treatment of these codes for purposes of the transition is necessary because we have no historical charge data that could be used for purposes of determining a transition payment amount for each newly established visit and consultation code.

Rules for the transition during CYs 1993 through 1995 are set forth in section 1848(a)(2)(B) of the Act. During those years, payment amounts for services subject to the transition provisions in CY 1992 would be paid as a blend of historical payment and the fee schedule. In CY 1996, payment for all services would be fully based on the fee schedule.

These transition rules are set forth in § 415.42 of the proposed regulations.

Because the fee schedule transition rules move payments below the fee schedule up toward the fee schedule faster than payments above the fee schedule move down, the transition has

a net cost in 1992. In order to achieve a budget-neutral CF, we proposed an offsetting downward adjustment in the CF. Because the CF would be permanently reduced, Medicare physician payments would be lower in years after 1992 than they would have been without this adjustment.

[Request for 10-year Transition]

Comment: Some commenters objected to the 5-year transition and requested a 10-year phase in of the fee schedule. They stated that physicians have made professional and personal financial commitments based upon historic Medicare payment rates and for many specialties, fee schedule payments will seriously adversely affect a physician's ability to meet them.

Response: The 5-year transition requirement is mandated by section 1848(a)(2) of the Act.

[Downward Adjustment of CF]

Comment: Virtually all commenters maintain that the Congress did not intend for us to adjust the CF downward to offset any potential cost associated with the asymmetrical transition rules in 1992. They believe that the statutory language should be interpreted to mean that the transition payment amounts must be computed without regard to the budget-neutrality requirement. Some commenters made even more specific statements that the phrase "without regard to this paragraph" at the end of sections 1848(a)(2)(A)(i) and (ii) of the Act means that the CF must be set without regard to the transition provisions. Other commenters noted that the CF adjustment we proposed would have the effect of making physician payments lower in years after 1992 than if the adjustment were not made. They believe that our proposed adjustment is contrary to clear Congressional intent and that we should have alerted Congress to the need for technical corrections to the law if they were needed. They stated that Congress's intent was that physician fee schedule implementation be budget-neutral and not a vehicle for reducing Medicare physician payments. Others believe that uncertainty over participation rates and the relationship of actual charges to the payment schedule make it impossible for us to project the transition effects with adequate precision.

Response: The transition-related adjustment to the CF set forth in the proposed rule resulted from our analysis of the interaction of two provisions of Public Law 101-239—those pertaining to the transition rules and those pertaining to budget neutrality. Because the fee

schedule transition rules move payments below the fee schedule up toward the fee schedule faster than payments above the fee schedule move down, the transition has a net cost in 1992. That the transition rules have a substantial net cost is indisputable and confirmed by the analyses of both the PPRC and the CBO. In the proposed rule, we proposed an offsetting downward adjustment of the CF of 6.2 percent in order to achieve budget neutrality in 1992. Because the CF would be permanently reduced, Medicare physician payments would be lower in years after 1992 than they would have been without this adjustment. In addition, the fact that the CF was the sole vehicle for the adjustment meant that a relatively large reduction in the CF was needed (the so-called "leveraging effect"). While we agreed that there was no evidence that the outyear payment reductions or the "leveraging effect" had been foreseen or intended by the drafters of the legislation, we stated that both resulted from the interactive effects of the legislative provisions as written.

Since the publication of the proposed rule in June, we have consulted extensively on this matter with representatives of the physician community, members of Congress, and other concerned parties who believed strongly that our proposed policy was counter to Congressional intent. We listened to these concerns and to the opinions of various legal experts who offered opinions on the interpretation of the statutory language. As a result of these consultations and our review of the many thousands of comments received on this topic, as well as further legal analysis by our own Office of the General Counsel, we have revised our policy on the transition adjustment to the CF. Some commenters suggested alternatives to the proposed policy along the lines of the final rule policy set forth below.

Under our revised approach, we will—

- Establish a budget-neutral full fee schedule, with a baseline adjustment to the CF of 6.5 percent (as discussed later in this section); and
- Apply transition rules and adjust only the AHPB (and not the CF) to account for higher spending under the transition and, thus, to restore budget neutrality in 1996. This required an adjustment to the AHPB of 5.5 percent. This approach would create first-year budget neutrality in a way that does not result the permanent \$7 billion (5 year) reduction in outlays due to the transition that would have occurred under the

proposed rule. It sets in place immediately a budget-neutral CF that will apply fully to all procedures by 1996. This approach is consistent with official budget estimates developed by both the Administration and the Congressional Budget Office, which showed no program costs or savings associated with implementation of the fee schedule. It is also responsive to the many thousands of commenters who stated their view that it was the intent of Congress to have a fully budget-neutral implementation of the physician fee schedule.

The authority for this adjustment is based on section 1848(c)(4), which provides the Secretary with authority to establish any "ancillary policies" necessary to implement the fee schedule. We believe it is necessary for us to adjust the AHPB for the dual purposes of achieving budget neutrality and not outyear budget reductions, which would be contrary to Congress' intent.

Comment: Some commenters suggested that we were not forthcoming about the issues associated with the transition. They maintained that if we believe that the law required a substantial downward adjustment of the CF to reconcile the transition provisions with the budget-neutrality requirement, then Congress should have been alerted early on to the possible need for a technical amendment to the legislation. Some commenters believe we were slow in alerting the Congress and the public about this problem and suggested that we saw this situation as an opportunity to reduce physician payments in a manner not intended by Congress and contrary to the budget-neutrality principle central to fee schedule implementation.

Response: We do not agree that we were slow to alert the Congress about this situation or that we attempted in any way to use ambiguity in the legislative language to effect budget savings. As a matter of fact, the possibility that the fee schedule provisions could result in post-1992 increases in fees which were less than might otherwise occur began to be discussed fairly soon after Pub. Law 101-239 was enacted on December 19, 1989. On page 25 of its March 1990 annual report, the PPRC clearly identified the situation:

*** since the 1992 stage of the transition will not be symmetric *** the fully implemented fee schedule will not be budget neutral. Simulations by the Commission suggest that after 1992 the conversion factor will be lower than one that would be budget neutral ***

In the following month (April 1990), CBO published "Physician Payment Reform Under Medicare", which included a preliminary estimate that the transition would produce a 3.9 percent reduction in Medicare payments after assumed volume and intensity responses.

At the time of the publication of the model fee schedule notice on September 4, 1990, we went on record in agreement with the PPRC and CBO that this was the expected effect of the statutory language. The model fee schedule indicated:

However, we find that program savings are likely to be derived in years after 1992 when the prior year's payments are blended with the full fee schedule amount. This is a result of the implementation mechanism prescribed by the legislation.

Because the model fee schedule was based on only partial and preliminary information from the Harvard study, it was not sufficiently complete to allow forecasting of out-year budget effects with any precision. Thus, the model fee schedule indicated:

Preliminary analysis suggests that some savings will result relative to a budget neutral baseline; however, a definitive analysis of the impact is not possible until all of the relative values, global fee definitions, and other factors are established.

While we clearly indicated our view that budget savings were likely the model fee schedule also expressed the possibility that, when further data became available, "the budget impact could be minimal."

More recently, in its 1991 annual report, PPRC more fully discussed the so-called "leveraging effect", which results from using the CF as the only vehicle for making adjustments to overall payments under the system. The PPRC estimated this effect as a 3 to 1 ratio; in other words, because the fee schedule CF only applies to some of the fees in 1992, a reduction in payments of 2 percent "multiplies" into a 6 percent CF reduction. Analysis of the issue by our actuaries, based on much more complete data, was not completed until about the same time as the PPRC's report was published. These analyses were done as expeditiously as possible in an effort to meet the May 1991 target date for publication of the proposed rule. Once all administration clearances were obtained, we published the data as part of the proposed rule on June 5, 1991 (56 FR 25820). We solicited public comment on this proposed policy along with all others in the proposed rule. In testimony before Congress and in other public forums shortly after publication of the proposed rule, we stated

consistently that we would consider other readings of the statute that would be both legally supportable and consistent with Congressional intent.

[Exemption of Radiology From Transition Adjustment]

Comment: Some commenters believe radiology services should be exempt from the transition adjustment that was made to restore budget neutrality in 1992 because radiologists began the transition to the fee schedule in 1989.

Response: We disagree. The statute requires that budget neutrality be established for all physician services paid under the fee schedule in 1992. Therefore, to the extent that there is an adjustment to reflect the transition asymmetry, all physicians' services will be affected.

[Use of 1991 Radiologist Fee Schedule CFs in Determining Physician Fee Schedule CF and AHPB Values]

Comment: Some commenters do not believe the 1991 radiologist fee schedule CFs are accurate for determining the total dollars attributable to radiology services. According to these commenters, some services are paid under the nuclear medicine fee schedule in 1991 and are generally paid at higher levels than under the radiologist fee schedule. These commenters believe the excess of payments for nuclear medicine services over what would have been under the radiologist fee schedule has been excluded from the CF calculation. Additionally, these commenters do not believe the 1991 radiology fee schedule CFs are accurate for determining the AHPBs. According to these commenters, the ACR audited several carriers and identified problems that required recalculation of the radiologist fee schedule CFs. These commenters, therefore, believe the CFs used in calculating the AHPBs for the physician fee schedule may be inadequate for determining transition payments for radiology services.

Response: The commenters are correct in indicating that payments under the nuclear medicine fee schedule were generally higher than payments for the same procedures under the radiologist fee schedule, but their conclusions about the effect of the payment differentials are incorrect. As pointed out on page 25818 of the proposed rule, the AHPBs for all nuclear medicine services are equal to the 1991 nuclear medicine fee schedule amounts computed under section 6105(b)(2) of Public Law 101-239. This policy is based on section 4102(g)(2)(B) of Public Law 101-508 and applies to all nuclear medicine procedures regardless of the

actual basis for payment of these services in 1991.

It is true that the ACR has identified problems with the computation of some radiologist fee schedule CFs since that payment method went into effect on April 1, 1989, and we have worked with the ACR in this effort. If we recomputed these CFs, the AHPBs reflect the resulting payment levels.

[Visit Crosswalk by Classes of Codes]

Comment: One commenter was confused regarding our discussion of the transition of visits in view of the change of definition for visit codes. In the proposed rule, we discussed the possibility of transitioning visits based upon the class of visits (for example, established office visits) rather than a code-to-code crosswalk from old visit codes to new visit codes. The commenter did not understand the distinction and stated that the example of each option was not illustrative since the results were the same for each approach.

Response: We received only one comment on the issue of how to transition visits in view of the change of definitions for visit codes. The issue is, in view of the change in definitions for all visit codes:

- Should we apply the transition tolerance and perform the transition blend for a class of visits by using a weighted average historic payment amount and fee schedule amount for the class of visits; or

- Should we make the comparison and do the transition on a code-by-code basis comparing the historic payment amount for the old visit code to a fee schedule amount for a new visit code?

We have decided to do the transition on a code-by-code basis for visit codes, using the same visit crosswalk (as discussed later in this section) we will use for the calculation of practice expense and malpractice RVUs and the CF. We are not convinced that doing the transition on the basis of a class of codes (rather than code-by-code) would result in a more meaningful transition since a direct code-to-code crosswalk would have to be used in either case. Moreover, the methodology for a transition on the basis of a class of codes is far more complex than doing the transition on a code by code basis. In addition, the absence of comments, except for one that expressed confusion regarding a transition based on a class of codes, supports our decision.

[Fee Levels for Private Carriers]

Comment: A commenter stated that comparability of fee levels with the non-

Medicare business of the carrier should not be considered when computing the AHPB.

Response: We believe we should retain comparability reductions in the AHPB, since the statutory definition of the AHPB in section 1848(a)(2)(D) of the Act requires that we take into account the old rules (the lesser of the prevailing and customary charges and other payment limitations imposed by law or regulations).

3. Other Issues Related to Determining the Initial CF

The statute specifically requires that the budget neutrality determination be made with respect to 1991 outlays. The initial budget neutral CF based on 1991 outlays is updated by the 1992 update determined under the MVPS. Computation of the initial CF requires predictions for CY 1991 with respect to: (1) Fees for each procedure in each area, consistent with the transition provisions, and (2) the frequency with which each procedure is performed. These predictions are very difficult, given that fee schedule implementation involves not only major changes in Medicare fees, but also simultaneous changes with respect to the uniform definition of services for surgical global fees and medical visits.

These two types of services (surgery and visits) account for more than 70 percent of Medicare payments for physician services. When the uniform definition becomes effective, there may be many services that are now paid for in global fees (or which are otherwise not now billed) that would be billed separately under the fee schedule. Conversely, services now billed and paid separately in some carrier areas would no longer be separately billable. With respect to visits, in moving to the physician fee schedule, any significant change or clarification of the service content of the codes would have major financial implications. In order to predict the budgetary impacts, there is a need to be able to cross reference the old and new coding of the same service. This process has been termed the "crosswalk." In the proposed rule, we explained our proposed "visit crosswalk" to be used in setting the CF, for determining practice expense and malpractice components for visits and consultations, and possibly for determining transition payment levels. We listed the assumptions made and the sources of data used and invited comment on this topic.

Physicians and beneficiaries could respond to the implementation of the fee schedule in the following ways:

- Physicians could bill appropriately under our proposed new definitions of services and associated payment conventions for services for which they do not currently bill.

- Beneficiaries could seek additional services because of lower out-of-pocket costs.

- Some physicians could bill for a higher level of services, particularly visits, or furnish more concurrent care, consultations, assistants at surgery, and diagnostic tests under the fee schedule.

Therefore, we proposed to take into account in setting the initial CF anticipated responses to price changes, policy standardization, etc., by physicians or beneficiaries. We explained how taking these factors into account is essential in order to achieve the budget neutrality required by law. We also explained why the MVPS alone is not an adequate mechanism to account for anticipated responses.

For physicians predicted to experience a net loss of Medicare revenues, in the proposed rule we assumed volume and intensity changes sufficient to offset 50 percent of the loss of Medicare revenues that would otherwise occur. We proposed to assume no change in volume and intensity by physicians expected to experience a net increase in Medicare revenues.

Taking all these factors into account and using these assumptions, we proposed an initial CF of \$30,000.1. This figure reflects the 1.9 percent update amount for 1992 discussed earlier.

[Crosswalk for New Visit and Consultation Codes]

Comment: Some commenters stated that the crosswalk we proposed for visit codes placed too many visits in the high RVU visit codes, thereby increasing the total number of RVUs in the system and reducing the CF inappropriately. They argued that we should use the PPRC projections of visit distributions, which were based on a log diary kept by a sample of physicians showing the duration of visits, as the means of estimating visit distributions for the new visit codes.

Response: We have not changed our visit crosswalk for office visits and hospital visits as the PPRC recommended, because we do not believe that the crosswalk should be based on duration of visits since the clinical content of the visit, and not time, is the primary factor physicians should consider in choosing a code. As we noted in the proposed rule, we had data from the National Ambulatory Medical Care Study that showed the average face-to-face time for certain

categories of visits. Of the 4 sources of information contained in the proposed rule, we found average time the least reliable as a way of predicting how physicians will likely bill under the new codes.

Rather, we based our crosswalk on what we believe is the closest clinically equivalent code, with duration of the visit being a secondary factor. We continue to believe that to do so is appropriate. To a lesser extent, we were also guided in this crosswalk by the results of the field study of the new visit codes.

We have changed the visit crosswalk for consultations because the CPT consultation codes differ from the draft codes we presented in the proposed rule. The CPT now has three classes of consultation codes: Office initial consultations, inpatient hospital consultations, and follow-up consultations. The CPT divided initial consultation codes into two classes (that is, office and inpatient) because the Harvard data showed significant differences in the work between inpatient and office consultations.

We have also created crosswalks for the other categories of visit codes for which the CPT has changed definitions and code numbers since the proposed rule was published. These crosswalks were also based primarily on clinical equivalency.

We have used the following crosswalk to estimate the volume of new visit codes for the CF calculation, to develop practice expense and malpractice RVUs for the new visit codes (based upon the weighted average historical payment bases discussed in more detail below as a visit transition comment), and to implement the transition for visit codes:

Crosswalk for CPT Evaluation and Management Codes New in 1992

[Note: The 1992 CPT codes assigned to these new code numbers differ from the temporary codes shown in the proposed rule.]

New code	Old code	Percentage
New Patient Office Visit*		
99201.....	90000	100
99202.....	90010	100
99203.....	90015	100
99204.....	90017	100
	90020	70
99205.....	90020	30
Established Patient Office Visit*		
99211.....	90030	100
99212.....	90040	100
99213.....	90050	100
99213.....	90060	100
99214.....	90070	100
99215.....	90080	100
Initial Hospital Visit*		
99221.....	90200	100

New code	Old code	Percentage
99222.....	90215	100
	90220	50
99223.....	90220	50
Subsequent Hospital Visit*		
99231.....	90240	100
	90250	80
	90260	50
99232.....	90250	20
	90260	50
	90270	100
99233.....	90280	100

Initial consultations:* Initial consultations are split into two series: one for inpatient hospital and nursing facility consultations and one for non-inpatient consultations. (The crosswalk for these new codes requires that place of service also be considered.)

New code (Non-inpatient)	Old code
99241.....	90600
99242.....	90605
99243.....	90610
99244.....	90620
99245.....	90630
New code (Hospital or NF)	
99251.....	90600
99252.....	90605
99253.....	90610
99254.....	90620
99255.....	90630

New code	Old code	Percentage
Follow-up Consultations*		
99261.....	90640	100
99262.....	90641	100
	90642	100
99263.....	90643	100

Emergency department codes. (The current 12 codes collapse to 5 new codes because of the elimination of the new/established distinction for these services.)

New code	Old code	Percentage
99281.....	90500	100
	90505	50
	90530	100
	90540	50
99282.....	90505	50
	90510	50
	90540	50
	90550	50
99283.....	90510	50
	90515	50
	90550	50
	90560	50
99284.....	90515	50
	90517	50
	90560	50
	90570	50
99285.....	90517	50
	90520	100
	90570	50
	90580	100

Old Codes for "nursing facility initial visits" become new codes for "comprehensive nursing assessments"

New code	Old code	Percentage
99301.....	90360	25
	90370	25
99302.....	90300	25
	90315	25
	90370	25
99303.....	90300	75
	90315	75
	90320	100

(Some visits involving comprehensive nursing assessments are now reported using subsequent care codes.)

New code	Old code	Percentage
Nursing Facility Subsequent Visits		
99311.....	90340	100
99312.....	90350	100
	90360	50
99313.....	90360	25
	90370	50
New Patient Domiciliary Home		
99321.....	90400	100
	90410	50
99322.....	90410	50
	90415	50
99323.....	90415	50
	90420	100
Established Patient Domiciliary Home		
99331.....	90430	100
	90440	50
99332.....	90440	50
	90450	100
	90460	50
99333.....	90460	50
	90470	100
New Patient Home Visits		
99341.....	90100	100
	90110	50
99342.....	90110	50
	90115	50
99343.....	90115	50
	90117	100
Established Patient Home Visits		
99351.....	90130	100
	90140	50
99352.....	90140	50
	90150	100
	90160	50
99353.....	90160	50
	90170	100

Additional new codes that directly correspond to an old code. The following old codes have been renumbered and can be crosswalked directly to the new code shown.

New code	Old code	Percentage
99431.....	90225	100% applies to all codes in this category
99433.....	90282	
99238.....	90292	
99288.....	90590	
99271.....	90650	
99272.....	90651	
99273.....	90652	
99274.....	90653	

New code	Old code	Percentage
99275.....	90654	
99499.....	90699	
99438.....	90755	
99432.....	90757	
99440.....	99152	
99291.....	99160	
99292.....	99162	

[MVPS to Adjust Payments for Volume Response]

Comment: Many commenters stated that the baseline adjustment necessary for budget neutrality (volume response adjustment) should be removed from the CF. They further stated that if any volume/intensity response did occur, the MVPS would adjust for this response. Several commenters suggested that the MVPS should be used on a more timely basis.

Response: We disagree. The MVPS will not correct for any volume/intensity response and will not maintain budget neutrality in 1992, which is required by statute. If there is no adjustment for behavior in 1992, volume and intensity increases and changes in billing practices will cause physician payment to exceed the budget-neutral level in 1992. The MVPS could theoretically adjust for some of these excessive payments in 1994, too late to assure budget neutrality in 1992. Moreover, our projections indicate that the maximum statutory reduction in the update factor of 2.5 percent for 1994 is already met even before any volume intensity response to the fee schedule occurs. Thus, according to our projections, the default MVPS has no capability of offsetting, even on a delayed basis, any of the expected response occurring in 1992. We cannot apply the MVPS on a "more timely" basis since the statute specifies the time frame for MVPS processes. Further, operational considerations may preclude the possibility of speeding up the MVPS in its current form.

There are five flaws built into the MVPS process that weaken its effectiveness as a means for controlling physician spending:

- Increases in payments to physicians in excess of the MVPS limits determine the new base to which all subsequent MVPS increases are applied. Volume and intensity increases in excess of the MVPS are thus passed through without penalty to subsequent years.
- Volume and intensity increases in excess of the MVPS have the effect of increasing subsequent default MVPS increases. Excessive increases in volume and intensity occurring in a

particular year are thus legitimized in the calculation of subsequent default MVPS increases.

- There are strict statutory limits on the maximum reduction in the update factor that can be made in response to increases in excess of the MVPS. These statutory limits thus directly reduce the ability of the MVPS to control excess volume and intensity increases.

- There is a statutory 2-year delay in the reduction of future update factors after excessive increases in volume and intensity have occurred.

The combination of these five specific statutory limitations on the administration of the MVPS guarantee that the MVPS will be largely ineffective in controlling the rate of increase in payments to physicians. More importantly, the statutory limitation on the reduction of the 1994 update factor (resulting from excessive increases in physician payments in 1992) is exceeded even before the baseline adjustment to the 1992 fee schedule is considered. Thus, it is possible that none of the baseline adjustment to the 1992 fee schedule would be offset by reductions in the default update factor under current law.

["Extreme" Assumptions for Volume Response]

Comment: Commenters state that we set the behavioral adjustment as a "worst-case assumption" or an "extreme" assumption. One of these commenters notes that because of the three-to-one leveraging, the 3 percent volume response adjustment reduces the CF by 10.5 percent. This commenter further proposes that, in light of great "uncertainty", the best compromise would be a 1 percent reduction in fees for the behavioral adjustment. Other commenters proposed that we use the 1 percent reduction in lieu of the 3 percent reduction. A commenter alleged that the Congress intended that the behavioral adjustment would, at most, be a fraction of a percentage point.

Response: We disagree that our baseline adjustment is an extreme assumption. This baseline adjustment is a technical adjustment needed to achieve budget neutrality in 1992. We are not alone in using a 50 percent assumption in making this adjustment. The Congressional Budget Office (CBO) also uses the same baseline adjustment in its estimates. In fact, a recent finding by the CBO suggests that none of the "cuts" in physician fees during the 1980s, including the physician fee freeze, had any impact on the rate of increase in Medicare payments to physicians. In a February 4, 1991 memorandum, the CBO states that, "Growth in spending

for physician's services has not slowed substantially relative to previous trends despite the disproportionate impact on physicians of budget reconciliation bills. Apparently, growth in the volume of physicians' services has accelerated by enough to offset most of the enacted reductions in payment rates."

In addition, PPRC staff research found evidence of a 56 percent utilization offset. Furthermore, a literature search by PPRC staff states "Other time series studies of total outlays also suggest the presence of a volume offset. The five studies reviewed in appendix A [of PPRC's 1991 Annual Report to Congress] all reported substantial increases in volume in response to fee freezes or cuts." In addition, our actuaries had been using the assumption of a 50 percent utilization adjustment consistently for over a decade before physician payment reform was considered. Our experience with the FY 1990 MVPS confirms that use of this adjustment allows our actuaries to make more accurate predictions of program expenditures. The FY 1990 MVPS was 9.1 percent. There are two important things to note about this number:

- The 9.1 percent figure included a statutorily specified factor of 0.5 percent as a desired reduction from the otherwise calculated increase. That is, the estimated spending baseline was 9.6 percent.

- One of the factors in determining the FY 1990 MVPS was changes in law or regulations affecting the baseline. In assessing the effects of Public Law 101-239, we used the same estimates that were used to "price" Public Law 101-239 provisions. As has been our longstanding policy, those savings estimates incorporated a baseline adjustment. Had a baseline adjustment not been used, the FY 1990 MVPS would have been 6.9 percent.

Our latest data show a rate of increase in Medicare physician spending of 10.0 percent for FY 1990. This figure is obviously closer to the MVPS determined with a baseline adjustment. In fact, had the FY 1990 MVPS not used a baseline adjustment in assessing changes in law or regulations affecting the baseline, the actual rate of increase in spending in FY 1990 would have been 3.1 percentage points in excess of the MVPS instead of 0.9 percentage points.

It is also significant to note that the overall FY 1991 MVPS of 7.3 percent would have been 1.7 percent if a baseline adjustment for the volume and intensity of services had not been used in determining the changes in law or regulations affecting the baseline. This is a difference of 5.6 percentage points.

Similarly, the overall FY 1992 MVPS is 10.0 percent. It would have been 7.4 percent if a baseline adjustment were not used in determining the changes in law or regulations affecting the baseline. Therefore, the FY 1992 MVPS is 2.6 percentage points higher than it would have been had we not used a baseline adjustment.

The significance of the baseline adjustment for the MVPS cannot be understated. For example, the cumulative difference between the MVPS with and without a baseline adjustment in FY 1990 and FY 1991 alone is 7.8 percentage points. If, as preliminary data suggests, the rate of increase in physician spending exceeds 7.3 percent in FY 1991, then the updates in both years should be reduced 7.8 percentage points beyond the reductions in the update already in the spending baseline.

It is interesting to note that we received no complaints about using the 50 percent baseline adjustment to increase the MVPS. Surely, the commenters would see the need for us to be consistent in the application of the baseline adjustment, both for the MVPS and the new fee schedule.

We find no justification for reducing the effect of this baseline adjustment to 1 percent. Any evidence to support a reduced adjustment is unsubstantiated and is inconsistent with the overwhelming evidence supporting the accuracy of the adjustment.

Finally, the effect of that baseline adjustment will no longer be "leveraged," since our approach to the transition adjustment has been modified, as described elsewhere. With the leveraging effect of the transition rules eliminated, the baseline adjustment to the CF becomes only 6.5 percent, as compared with the 10.5 percent adjustment in the proposed rule.

[Effects of the Physician Fee Freeze]

Comment: Some commenters contend that the experience during the physician fee freeze (which began July 1, 1984 and ended April 30, 1986) proves that there is no increase in volume and intensity of services when fees are constrained. They indicate that the growth in volume and intensity for the 5 years after 1984, when severe constraints were applied, was about 1 percent lower than the growth in volume and intensity for the 5 years before 1984. Further, they use the information provided by the HCFA actuaries in the "Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund" to support their statement. They argue that this implies that the CF should be

increased, not decreased, in adjusting for volume and intensity changes due to the new fee schedule.

Response: Although a superficial examination of the tables in the "Trustees Report" makes it appear that volume and intensity had decreased during the fee freeze, a more sophisticated analysis shows that just the opposite was true. When volume and intensity increases are examined separately for the first and second years of the freeze and disaggregated into in-hospital increases and non-hospital increases to ascertain the impact of the prospective payment system (PPS) on volume and intensity increases, the experience during the physician fee freeze indicates that physician volume

and intensity increased substantially in response to constraints on fee increases.

The following table displays increases in inpatient hospital days, and increases in physician volume and intensity during each of the years of the freeze (1985 and 1986) and during the 5 years before and after the freeze. The table shows that during the second year of the freeze, the total increase in physician volume and intensity was 10 percent, one of the three largest increases in the history of the Medicare program. A large 12.3 percent decline in inpatient hospital days coincided with a large 8.6 percent decline in in-hospital volume and intensity during the first year of the freeze. However, non-hospital volume and intensity increased by 20.6 percent. If a mere shifting from in-hospital to

non-hospital services explained the large differentials in in-hospital and non-hospital volume and intensity increases in 1985, then we would expect that the total volume and intensity increase in 1986 (when there was only a small decline in inpatient hospital days) would be similar in magnitude to the 1985 increase. This was not the case. Thus, the total volume and intensity increases in 1985 would have been just as large as the total volume and intensity increase in 1986 if it had not been for the impact of the Medicare prospective payment system for hospitals on in-hospital volume and intensity.

Illustration of Impact of Fee Freeze and PPS on Physician Volume and Intensity Increases

Year ending June 30	Annual increase in inpatient hospital days (percent)	Annual physician volume and intensity increase		
		Total ¹ (percent)	In-hospital (percent)	Non-hospital (percent)
1980-1984	1.2	7.1	5.6	9.9
1985-1989	-3.2	6.3	-0.4	14.6
1985	-12.3	3.3	-8.6	20.6
1986	-3.3	10.0	3.7	17.0

NOTE: The Physician fee freeze was effective July 1, 1984 and ended April 30, 1986.

¹ Table A3, 1991 SMI Trustees Report.

[Time for More Visits]

Comment: Several comments were received that stated that there is not enough time in the day to add more visits.

Response: While some physicians do have a certain amount of flexibility with respect to the number of visits they furnish, others have less flexibility. However, physician income can be increased by means other than increasing the number of visits or procedures. Billing for an inappropriately high level of service and billing separately for services that should be included in another code are two widely discussed practices that do not necessarily involve additional physician time. In addition, physicians can increase the intensity of services furnished without expending additional time.

[Prevention of Unnecessary Care]

Comment: One commenter suggested that the behavioral responses such as providing medically unnecessary care should be prevented by mechanisms such as physician profiling and peer review rather than the behavior offset.

Response: We incorporated the baseline adjustment to compensate for increases in volume and intensity

beyond what would have occurred if the fee schedule had not been implemented. It is not practicable for us to conduct the sort of intense utilization review that would be necessary for us to review this aspect of fee schedule implementation. This effort would be costly and would be very intrusive from the standpoint of physicians.

[Limitations on Volume Response]

Comment: Many commenters stated that their practices are derived from referrals and that they cannot increase the volume of their services to increase revenue. Others alleged that, since psychiatric services are billed per time unit, and with a 50 percent coinsurance that discourages patient demand for services, the volume of psychiatric services will not increase. Other commenters stated that they cannot shorten 50-minute time periods. Most of these commenters claim that their specialties should not be subjected to the volume response adjustment. We also received comments that, even with overpriced procedure reductions, the volume of cataract procedures on Medicare beneficiaries is slowing down, perhaps decreasing, and that it is not possible for ophthalmologists to increase volume, and that in fact they did not increase volume of services.

Response: The baseline adjustment is applied to the CF to assure budget neutrality in the light of a behavioral response to changing practice income. We project that, on average, 50 percent of practice losses will be made up by changes in volume and intensity of services. This does not imply that each practice will make up 50 percent of its losses. Some practices will make up more than 50 percent of their losses while other practices will be less successful in making up losses. While there may be limits to the ultimate volume on some procedures, this limitation, however, does not preclude other changes in billing practices leading to increases in volume and intensity.

We cannot exclude selected specialties from the baseline adjustment for the following reasons:

- (1) The fee schedule applies to procedures, not to specialties. We cannot have different prices for a procedure that varies by specialty.
- (2) To preserve the relative pricing relationship among the procedures, the baseline adjustment must be applied uniformly to the CF, not to selected procedures.

Comment: One commenter presented a study that the commenter claimed

demonstrated that the volume and intensity of radiology services do not increase if payments are reduced.

Response: We reviewed this study and found that the study's hypothesis is different from the hypothesis underlying the baseline adjustment in the proposed rule. The study hypothesized that when payments for specific services (in this case radiology services) are reduced, the volume of those specific services is increased. On the other hand, the hypothesis underlying the baseline adjustment in the proposed rule projects a net reduction in Medicare practice revenue results in a behavioral response that offsets half of the reduction in revenue that would otherwise occur. The behavioral response is not assumed to be limited to the procedures for which payment was reduced. Thus the study submitted by this commenter is not relevant to the behavioral response assumed in the proposed rule.

Moreover, other commenters have specifically stated that radiologists do exert control over their volume and do respond behaviorally to reductions in fees. One commenter, a practicing radiologist, stated: "In fact, radiologists typically recommend imaging studies to patients' attending physicians * * *". This commenter also noted "My radiology partners and I were able to increase our net collections in the face of reduced total patient volume by adjusting our fees upward at intervals, by providing new services and by learning to master the ever-changing CPT coding system to describe and bill for our services in the best reimbursable manner. Thus the 'reductions' in Medicare reimbursement for radiology services in 1989, 1990, and 1991 did not diminish our income; on the contrary, we were able to enhance our net revenue."

Therefore, we have not made a special adjustment in the behavioral (volume response) assumptions with regard to radiologists.

[Rural Versus Urban Physician Encounters]

Comment: Some commenters stated that rural physicians already have more patient encounters than urban physicians so that it would be more difficult for rural physicians to increase patient volume.

Response: We expect that most rural physicians will have net practice gains under the new fee schedule so that they would have no need to offset reductions in allowed fees.

[Non-Medicare Patient Volume]

Comment: Commenters stated that they would see more non-Medicare

patients and fewer Medicare patients in response to the fee schedule. Consequently, the behavior offset would not be necessary.

Response: A few physicians may be able to see more non-Medicare patients, but in the overall situation, these Medicare patients will still need medical services, and we don't expect that Medicare beneficiaries will be abandoned by physicians.

[Volume Response Adjustment Studies]

Comment: Many commenters cited studies that had conflicting conclusions. Some of these studies demonstrated an increase in volume/intensity in the behavioral response to fee reductions while other studies showed no response, or even a volume reduction in response to fee reductions. The commenters stated that because of these conflicting studies, there is no justification for the volume response adjustment. Commenters particularly criticized the "Colorado" study as being too old and flawed. One commenter even claimed that HCFA's own "expert", in a published article, could not recommend a behavioral adjustment because of uncertainties in the ability of affected practices to increase volume. Other commenters submitted studies that purported to support their statements that a volume response adjustment is unnecessary.

Response: Some of the studies cited by commenters analyzed only the volume of procedures within the scope of the study. The studies did not analyze complete practices, nor any changing mix of procedures, or any increase in the volume of other procedures. Consequently, these studies do not refute the baseline adjustment. We agree that the "Colorado" study has limitations, since it was based upon one State, discarded the results applicable to surgeons as not believable, and is quite old and possibly out of date. We did not base our adjustment on the results of that study. Our adjustment is based on our experience of the impact on program outlays due to legislated changes in allowed charges under Medicare. (See earlier discussion of this issue.)

The article by HCFA staff cited by the commenter also contained an extensive discussion of many of the possible ways that physicians can increase volume and intensity of services. (This article was "Volume and Intensity of Medicare physicians' services: An overview" published in the Summer 1990 issue of the Health Care Financing Review (Vol. 11, No. 4)). The article stated that while it would be difficult for some specialties to increase volume, other specialties will

be able to increase volume and intensity to make up losses.

In summary, we found that the studies submitted by the commenters inadequately supported their allegations.

[Evidence To Support Volume Offset Adjustment]

Comment: Many commenters objected to the use of volume response adjustment claiming there was little or no evidence to support this supposition.

Response: It is incorrect to say that there is little or no evidence to support the use of the baseline adjustment. The following is a partial list and précis of articles on this subject.

Federal research. 1. Congressional Budget Office, "Physician Payment Reform Under Medicare," April 1990.

Staff econometric study of volume changes in response to Medicare payment changes in Colorado in 1977 for general practitioners and internists indicates that " * * * increased volume would offset about half of the change in practice receipts that would result initially from changes in Medicare's payment policies." (p. 76)

2. Congressional Budget Office, "Rising Health Care Costs: Causes, Implications, and Strategies," April 1991.

In the absence of any changes in the quantity or mix of services, a reduction in price should lead to lower total expenditures for that service, but changes in the quantity or mix of services typically do occur * * *. Studies on the effect of fee freezes or controls on physicians' prices indicate that they result in a pronounced volume offset that substantially reduces the anticipated savings from these policies. (p. 41) (emphasis added)

3. Christensen, "Volume Responses to Exogenous Changes in Medicare's Payment Policies: Technical Memorandum," Congressional Budget Office, August 1989.

Multivariate regression analysis of payment changes in Colorado in 1977 was performed and the results reveal that general practitioners and internists make a significant response to payment changes. The results suggest that a 1 percent decline in payment results in a 0.5 percent increase in volume. Although general surgeons were affected, volume responses were not reported, as the author concluded they were not credible.

The author contends that during a time of fee constraints, volume responses occur for two reasons. First, since the out-of-pocket expenses are reduced, beneficiaries may demand more services. Second, physicians may induce demand in order to maintain an equivalent level of income.

4. Physician Payment Review Commission, Annual Report to Congress, April 1991.

"Results show that each percentage point reduction in fees resulted in a 0.56 percentage point increase in volume, roughly in line with OACT's [HCFA's Office of the Actuary] traditional assumption of a 50 percent behavioral offset." (p. 123)

5. General Accounting Office, Report to the Chairman, Subcommittee on Health, Committee on Ways and Means, entitled "Medicare: Further Changes Needed to Reduce Program and Beneficiary Costs", May 1991."

"Past efforts to control physician payments by limiting the fees paid have been largely unsuccessful because volume increases have offset the savings from constraining fees."

6. Falk and Langwell, Congressional Research Service, "Growth in the Volume of Medicare Physician Services: A Framework for Analysis," June 28, 1988.

The authors reviewed Medicare physician services data since 1968 and found four peak periods when volume increases occurred. These increases peaked: (1) In 1968 at the start up of the Supplementary Medical Insurance (SMI) program; (2) under fee constraints in 1973 during Economic Stabilization Program (ESP); (3) in 1983 after a drop in the rate of growth in 1982; and, (4) in 1986 during the Public Law 98-369 fee freeze.

The authors concluded that in 1986, volume increased by more than 10 percent and " * * * since fees were frozen nearly all of the growth in SMI expenditures between July 1, 1985 and June 30, 1986 was accounted for by an increase in volume" (p. 9).

7. Health Care Financing Administration, Office of the Actuary, "Impact of Physician Fee Freeze on Volume and Intensity Increases in Physician Services," Spring 1991.

When volume and intensity increases are examined separately for the first and second years of the freeze, and when the volume and intensity increases are disaggregated into in-hospital increases and non-hospital increases to ascertain the impact of PPS on the increase, there is substantial evidence that physician volume and intensity increases were in response to constraints on fees.

This study revealed that after making adjustments for the effect of PPS, volume and intensity reached the highest level in the history of the program.

Academic research. 8. Evans, "Supplier-Induced Demand: Some Empirical Evidence and Implications," The Economics of Health and Medical

Care, ed., Mark Perlman, (New York: Wiley and Sons, 1974).

Using empirical evidence from Canada and the United States from the 1960's and 1970's, the author concluded that since a physician is able to influence the demand for his or her own services, policies to limit price can lead to a volume response.

9. Paringer, "Price Controls, Physicians' Fees, Output and Revenue from Public Medical Programs: Evidence from Five Specialties," The Urban Institute, November 1979.

Price controls imposed during the Economic Stabilization Program were effective in constraining the increase in the average price of physicians' services * * * [H]owever, price controls did not limit the increase in physicians' incomes from the Medicare program. The ability of physicians to increase the number of services provided and to alter the mix of services as outlined in this study, provides important information on the usefulness of price controls and fee schedules as a means of constraining expenditures for physicians' services (p. 51).

10. Holahan and Scanlon, "Price Controls, Physician Fees, and Physician Incomes from Medicare and Medicaid," The Urban Institute, Health Care Financing Grants and Contracts Report, HEW Pub. Number 03006, Washington, DC; Health Care Financing Administration, 1979.

In analyzing the effect of controls on physician fees imposed during the Economic Stabilization Program in the California Medicaid program from 1972 to 1975, the authors found that price controls were not effective in controlling expenditures for physicians' services. Controls were effective in limiting increases in unit prices, but any intent to limit expenditures was thwarted by physicians through (1) changes to a more complex service mix and (2) increases in the number of services furnished.

11-13. Rice and McCall, "Changes in Medicare Reimbursement in Colorado: Impact on Physicians' Economic Behavior," Health Care Financing Review 3(4):67-86, June 1982.

Rice, "Economic Incentive and Physician Practice: An Examination of Medicare Participation Decisions and Physician-Induced Demand," Doctoral dissertation, September 1982.

Rice, "The Impact of Changing Medicare Reimbursement Rates on Physician-Induced Demand," Medical Care 21(8):803-815, August 1983.

These three reports examined the effect of payment changes in Colorado in 1977. All three reports find that there was a negative correlation between changes in Medicare payments and the average intensity of medical services. That is, physicians who saw a decline in

their Medicare payment furnished more intensive services.

In summarizing the results of his analysis, the author concludes:

* * * that reimbursement reductions will make it more likely that physicians will induce demand for the services they provide to patients. In other words, if policymakers reduce physician payment levels for services under public programs, these policies are likely to be ineffective in reducing program costs, because physicians will increase the number of and/or intensity of services they order. Again, this finding does not imply that physicians provide unnecessary services, only a different quantity or mix of services than they would otherwise.

(Doctoral Dissertation)

14. Wilensky and Rossiter, "The Relative Importance of Physician-Induced Demand in the Demand for Medical Care," The Milbank Memorial Fund Quarterly/Health and Society, Vol 61, Number 2, 1983.

* * * The amount paid by insurance and/or the depth of insurance coverage are consistently important in explaining higher physician-initiated demand. The less an individual pays for medical care, the more likely is the physician to initiate visits and related expenditures. This, it should be noted, is in addition to the individual's being more likely to initiate visits and expenditures as a result of lower out-of-pocket costs, * * * Our findings indicate that not only would individuals have increased their demand for medical care, but that physicians would have initiated more visits as well. (emphasis added) (p. 271)

15. Gabel and Rice, "Reducing Public Expenditures for Physician Services: The Price of Paying Less," The Journal of Health Politics, Policy and Law, Volume 9, Number 4, Winter 1984.

The authors reviewed the literature and found evidence that cutting or controlling physician payment levels will not successfully control program expenditures.

16. Cromwell and Mitchell, "Physician-Induced Demand for Surgery," The Journal of Health Economics, 5(1986) 293-313, 1986.

The authors conclude that in the physician market, fee regulation may be met by increases in discretionary services, including some surgical procedures.

17. Cotter, "Physician Service Coverage Under Medicare: History, Performance, and Evaluation," American Medical Association, Center for Health Policy Research, 1987.

The author analyzed the 18 percent average annual increase in Medicare payments to physicians from 1975 through 1982 and concludes that: "Although the measures taken to modify physician payment have been extensive,

their impact in restraining program expenditures have been (sic) less than hoped. In fact, many of the modifications have had the effect of increasing outlays." (p. 34)

18. Wedig, "Trends in Part B Expenditures Before and After the Freeze: Empirical Evidence and Explanations," November 1988.

In analyzing Medicare Part B inflation under the fee freeze of 1983 through 1986, the authors found that: "While the number of patient contacts or visits has remained relatively constant over the past 20 years, part B expenditures have exploded because the intensity of care per visit has increased as well as increases in the numbers of surgeries, tests, etc. This experience has been even more exaggerated in recent years." (p. 32)

19. Holahan, Welch, and Zuckerman; "Toward Simulating A Volume Response to the RBRVS Fee Schedule," The Urban Institute, January 1989.

The authors had two primary conclusions.

First, volume will change in response to a change in Medicare allowed fees. This implies that simulations that do not allow for these responses can produce misleading results with respect to aggregate spending and distributional effects. Second, the strongest consensus on both the direction and magnitude of these volume changes exists for surgical services. As fees for these services are reduced by the RBRVS, surgical volumes can be expected to rise * * * (p. 10)

20. Mitchell, Wedig, and Cromwell; "The Medicare Physician Fee Freeze: What Really Happened?" Health Affairs, Spring 1989.

During the 1984 through 1986 freeze on Medicare physician fees, physician expenditures increase more than 29.5 percent. The major increases were observed in surgery and diagnostic tests. The authors concluded that while there was in general a rapid growth in expenditures during the fee freeze, services which are physician initiated grew at a disproportionately higher rate.

21. Rice and Labelle, "Do Physicians Induce Demand for Medical Services?," Journal of Health Politics, Policy and Law, Fall 1989.

The authors respond to an article by Feldman and Sloan published in 1988 which did not support the notion that physicians generate demand to avoid the impact of government price controls. In contrast, Rice and Labelle have found significant evidence that physicians do respond to price controls.

22. Holahan, Dor, and Zuckerman; "Understanding the Recent Growth in Medicare Physician Expenditures," The Journal of the American Medical

Association, Volume 263; Number 12; March 23, 1990.

The original research for this article was funded by HCFA and was presented in Holahan, Dor, and Zuckerman; "Medicare Physician Expenditures: Sorting Out the Reasons for Growth," Urban Institute Report 3650-06; January 1990.

The authors attempted to study changes in volume from 1983 to 1985 using Medicare physician claims data. Although the authors concluded that the freeze on physicians' fees did not have a major impact on the volume of physicians' services, a closer look at the data supports a baseline adjustment. A CBO analysis of the results, in a CBO memorandum dated August 10, 1990, indicates: "that the additional volume induced by the changes in Medicare's payment provisions offset about 56 percent of the potential drop in federal spending for physicians' services that the freeze might have caused."

23. Hsiao et al., "Payment Regulations—What Impacts Did They Have?," Working paper prepared by Harvard University for the Joint Research Conference of the Society of Actuaries and Association for Health Services Research, June 5, 1991.

Following a critical review of the literature to evaluate the impacts of regulatory efforts to control the rapid inflation of health expenditures, the authors concluded that:

In sum, there is strong evidence that physicians can respond to fee regulations by inducing utilization, and that the amount of inducement varies by specialty. In addition, physicians can also alter the mix of services to offset fee reductions. (p. 30)

International research. 24. Barer, Evans, and LaBelle; "Fee Controls as Cost Control," The Milbank Quarterly, Volume 66; Number 1, 1988.

A comprehensive review of Canadian history with physician fee controls reveals that for Canada as a whole, fee controls have been successful in controlling the rate of growth in physician expenditures. However, the authors concluded that physicians tended to respond to fee constraints by furnishing more services.

25. Labelle, Hurley, and Rice; "Financial Incentives and Medical Practice: Evidence from Ontario on the Effect of Changes in Physician Fees on Medical Care Utilization," Prepared for the Physician Payment Review Commission; Background Paper Number 89-3, December 1989.

An analysis of the impact in fee changes on utilization of 28 selected procedures in Ontario, Canada. For those procedures which had undergone

a one-time large change in relative fees, 55 percent exhibited a significant utilization response.

[Level of Submitted Charges]

Comment: Some commenters challenged the assumption that all physicians will submit charges at or above the new fee schedule. One commenter claims that we reduced the CF by 6.6 percent because we assumed that all charges would be submitted at or above the fee schedule. Another asserted, after looking at the BMAD Provider file, that 25 percent of allowed charges were less than the prevailing charge.

Response: We have refined our assumptions about the extent to which physicians will bill patients for amounts less than the fee schedule amount. Specifically, we are assuming in this final rule that those physicians who are predicted to receive net increases in Medicare payments and who have previously been charging less than the prevailing charge will increase their submitted charges by half the difference between their submitted charges and the new fee schedule amounts in 1992. Further, we assume that by 1996 this group of physicians will have increased all charges so as to close 90 percent of the gap between their submitted charges and the new fee schedule amount. We are assuming that winning physicians will take some time to adjust their charges to the new fee schedule. We are not assuming that all physicians will immediately increase their charges to the fee schedule, but we continue to believe that in the long run almost all physicians will charge the full fee schedule amounts. The commenter who asserted that 25 percent of allowed charges were less than the fee schedule amounts apparently did not consider the customary charge in performing the analysis.

[Modification of Practice Behavior to Offset Losses]

Comment: We received several comments stating that physician practices that face financial losses will modify practice behavior to offset the losses. Some of these commenters made statements such as "In my experience in private practice (now retired) all efforts to control physician reimbursements from Medicare or Medicaid were met by intensive gaming of the system.", and "The 'reductions' in Medicare reimbursement for radiology services in 1989, 1990 and 1991 did not diminish our income; on the contrary, we were able to enhance our net revenue."

Response: We agree that these practices have occurred in the past, and we expect these practices to enhance income as a result of the new fee schedule. Consequently, to preserve budget neutrality, we will apply a baseline adjustment to the new fee schedule.

[Excessive Physician Payment]

Comment: Several commenters stated that physician payment is excessive and that they applaud our efforts to bring payments under control. Some of their statements included "I don't think that the American taxpayers are under any obligation to gild our nest, which they have already feathered very nicely.", "I think that their opposition is based on excessive greed and dishonesty.", "I even wish the cuts were deeper and brought into effect immediately rather than gradually over the next 5 years.", and "We must reduce fees and charges which have been too high."

Response: Even though we understand the concerns of these commenters, we are unable to reduce aggregate allowed payments because the statute requires that the fee schedule be set in a budget-neutral manner. Consequently, we have set the CF using our "best" technical assumptions and methodologies to assure that projected payments are neither too high, nor too low as compared to the budget-neutral level.

[Volume Decrease for Increased Payment]

Comment: Commenters suggested that we should assume that there will be a volume decrease for practices that receive increased payments under the new fee schedule.

Response: We disagree. We expect that patient demand for services will not decrease simply because payable fees increase. Only one study, the Colorado study, found a volume decrease in response to increased payments, and this study had several severe limitations that have already been delineated. Numerous commenters stated that this study, because of its limitations, should not be relied upon. We agree. Consequently, we think it inappropriate to assume that demand for services will decrease when fees increase.

[Elimination of Volume Response Adjustment]

Comment: A commenter stated that "If HCFA is unwilling to eliminate this provision volume response adjustment, it should be replaced with a procedure-specific retrospective system."

Response: A retrospective procedure-specific system is not feasible and

would not satisfy the statutory requirement for budget neutrality.

[PPS Experience]

Comment: A commenter stated LASER - SHARED—PS2HPLAID.PRSies that lead to overpayment of physicians under the RBRVS, * * *

Response: PPS corrections initiated by the Secretary and accepted by the Congress never attempted to recover past overpayments; they were intended solely to halt the continuation of inappropriate payment levels into the future. To maintain program integrity, we must set the initial physician payment rates to insure that the correct amount is spent. Past experience demonstrates that correction of overexpenditures is never fully successful.

[Lack of Volume Offset Adjustment For PPS]

Comment: A commenter stated that when we implemented the PPS for hospitals, we did not incorporate a volume response adjustment. Consequently, we should not incorporate a behavioral offset for physician payments.

Response: The assumption of this commenter is incorrect. When PPS was implemented we anticipated that DRG case mix would increase when we initially set budget neutrality, and we made an appropriate adjustment for this "behavioral response". The statement of the commenter that we applied no baseline adjustment to PPS is factually incorrect.

[Inconsistencies of Volume Response Adjustment]

Comment: A commenter claims that our statement in the proposed rule that "We do not believe physicians would subject their patients to risk merely to secure additional payment" is inconsistent with the volume response adjustment. The commenter further alleged that the volume response adjustment is demeaning to physicians.

Response: This comment implies that the only kind of behavioral response possible is the kind of response that would "subject their patients to risk merely to secure additional payment." However, a behavioral response involving billing for an inappropriately high level of service, billing separately for services that should be included in another code, or performing additional tests generally does not involve additional risk to the patient. Thus, the comment cited by the commenter does not constitute a contradiction of the assumption of a baseline adjustment.

Although the commenter asserts that the behavioral assumption is demeaning to physicians and patients, the baseline adjustment is, nevertheless, an assumption that has been repeatedly proven to be appropriate when physician fees have been reduced. The assumption is well documented in the economic literature.

As a matter of fact, the utilization offset was used in calculating the legislative savings for Public Law 101-239 and Public Law 101-508 and had the effect of increasing the 1990 MVPS by 2.2 percent and increasing the 1991 MVPS by 5.6 percent.

[Volume Response Adjustment and Technological Advances]

Comment: One commenter indicated that the volume response adjustment fails to take into account technological advances that have the effect of reducing the frequency of performance of some radiological procedures such as barium examinations and intravenous urograms.

Response: It would be difficult to fashion a baseline adjustment to take into account variables affecting individual procedures; however, these situations should be brought to our attention for possible future refinements of our baseline adjustment methodology.

F. Data Used to Develop the Fee Schedule

In developing the proposed rule, two sources of national level claims data were used: (1) The NCH, and (2) BMAD files (Procedure, Provider, and Beneficiary files). Because we wanted to use the most current and complete data available, we primarily used "aged" 1989 BMAD files for calculating the national CF and for calculating the practice expense and malpractice RVUs.

For the proposed rule, the BMAD files were validated by comparing the BMAD Procedure file data for selected carriers to the most recently available (that is, 1987 or 1988) 100 percent Medicare claims data collected by independent sources. We concluded that, although there were some data reporting differences, overall the data were accurate and reliable.

Because we are required to compute a CF that would provide budget-neutral outlays for 1991, in developing the proposed rule, the BMAD files were adjusted to reflect 1991 payment rules. In general this aging process was accomplished by adjusting 1989 and 1990 prevailing charges for changes made by both Public Law 101-239 and Public Law 101-508.

Certain sections of Public Law 101-239 required data adjustments. Accordingly, we made adjustments for overvalued procedures, designated specialty, radiology reduction, and MEI differential updates.

Certain sections of Public Law 101-508 required additional data adjustments. Accordingly, in developing the proposed rule we made additional adjustments for overvalued procedures, anesthesia and radiology reductions, pathology services, technical components of diagnostic tests, primary care, reduction of 6.5 percent for all physician procedures other than those listed above, primary care floor, assistant-at-surgery, technical components of certain scanning services, interpretation of EKGs, and new physicians/PTs/OTs. These files were adjusted further to reflect procedure code changes and standardization of payment policies.

[Data Editing Methodology]

Comment: Commenters indicated that our data editing methodology for eliminating aberrant data records biased the estimate of payment levels downward. (For example, the PPRC estimated the CF was 2 percent too low because of our data editing methodology.) Deficiencies in the trimming process identified by commenters included: (1) An assumption that the data are approximately normally distributed although they in fact have a right-hand tail and are roughly normal only in logarithmic form; (2) far too much trimming because of the use of two standard deviations to mark data to be discarded; and (3) failure to eliminate records with zero allowed charges. These commenters indicated that if we believe some statistical trimming is necessary, then the trimming must recognize: (1) The approximately log-normal structure of the data and (2) the wide variation in payment levels that actually exists.

In addition, some commenters indicated that it was not clear that any statistical trimming was appropriate, given that BMAD records are aggregated and do not represent individual services.

Commenters' suggestions for editing data included the following:

- Eliminate records with an error flag.
- Eliminate records with allowed charges of zero.
- Eliminate records with net frequency of service of zero.
- Eliminate records with net submitted charges less than allowed charges.
- Eliminate all records with allowed charge per service greater than 3 times the mean or less than one-third of the

mean. The mean should be established after the four-step cleaning is completed and should be compiled separately by place of service when differences in payment by place of service are a possibility.

Another suggestion was to do the following:

- Take the logarithm of allowed charge per service.
- After transformation, eliminate records more than three standard deviations from the mean.
- Transform all retained records into the unlogged form for calculating allowed charges that will be applied to the 1991 payment base.

Response: For the final rule, we have modified our data editing methodology in a way that is generally consistent with the first approach discussed above. This methodology is also similar to the "cleansing" method used by some carriers in calculating reasonable charges. In developing our analytic file, we eliminated all records with an allowed charge per service greater than 3 times the national mean allowed charge or less than one-third of the national mean allowed charge.

We chose this approach because we believe it responds to commenters' concerns that our original approach (that is, eliminating records that are greater or less than 2 standard deviations from the national mean allowed charge) inappropriately excluded more high charge data than low charge data. However, our analyses show that, in the proposed rule, the effect on the CF if we had used this alternative editing method would have been small; the CF would have only increased by about 0.5 percent, not the 2 percent increase suggested by some commenters. Although we did not specifically provide details in the proposed rule, we completed data editing steps 2 and 3 above as part of our routine file development for both the proposed rule and for this final rule. We purposely did not remove all records with error flags because the flag merely indicates one or more fields on the record are incorrect, including data fields not used for fee schedule development. Likewise, we did not do step 4 (remove records when submitted charges were less than allowed charges), because the BMAD procedure file upon which our analytic file is based is an aggregate file. This situation occurred relatively infrequently, but removal of these records could inappropriately reduce the total allowed charges for some services. The overall impact of the new trimming method was to raise the CF by approximately one-half percent.

[Accounting for Case Mix Changes]

Comment: In the proposed rule, we based the computation of the CF on the frequency and mix of services that existed in 1989 because that was the most current data available. However, in the proposed rule we noted our intent to adjust the final rule to account for changes in the mix of services furnished between 1989 and 1991. Commenters generally agreed with this approach. They believe there is a tendency toward a more rapid than average increase among newer, more technical services. These services tend to have relatively high allowed charges per RVU. Thus, the changing mix of services contributes to an increase in allowed charges per RVU. These commenters indicated that adjustments for changes in volume of service might appropriately be made by either individual service or by categories of service. Some commenters suggested that categories, if used, should be based on technology and newness of service.

Response: For this final rule, we increased the CF by 1 percent to account for case mix changes between 1989 and 1991. This adjustment was based on an analysis of case mix changes between 1989 (BMAD) and 1991 (CWF).

[Proposed Rule Not Based on Current Data]

Comment: Commenters expressed concern that the proposed fee schedule was not based on current or correct data. References in the proposed rule are made to 1987, 1988, and 1989 research studies and reports. However, physicians' expenses have risen dramatically in the past 2 years, and this was not taken into consideration in developing the proposed rule.

Response: In developing the fee schedule, we used the most current data and information available. It usually takes 1 or more years to collect and analyze the data necessary to address many of the very complex payment issues that have been considered in developing the new fee schedule. Furthermore, to the extent feasible, we "aged" our data files to reflect 1991 payments, as discussed elsewhere in this preamble.

[Payment Increases Less Than Inflation]

Comment: Some commenters indicated that because fee schedule payments are being compared to the prevailing charges from this year, it eliminates the chance that payments will be more equitable. The MEI has restricted payments based on the 1971 fee screen data. The MEI has increased only approximately 130 percent since 1971. The consumer price index has

increased by 400 percent. This means that by comparing prevailing charges (historical payment base) to the fee schedule, it is impossible to receive an equitable increase.

Response: During the transition period, fee schedule payments will be compared to the "adjusted historical payment basis" as specified by statute. We have little flexibility with regard to how this provision is implemented.

[Accuracy of Adjusted Historical Payment Basis (AHPB) Calculations by Carriers]

Comment: Some commenters indicated doubt that carriers have the ability to correctly make the calculations for the transition period. These commenters believe information concerning volume of services on a Statewide basis should be provided in detail to anyone who requests the data so that the calculations performed by the carriers can be reviewed.

Response: The carriers have been provided with specific instructions to provide these data to the public upon request.

[Data for Psychiatric Services]

Comment: Commenters believe significant errors are present in the 1989 BMAD files or in our use of the data pertaining to psychiatric services. Because of the complex regulations and legislative history of Medicare payment for psychiatry (such as, the \$250 cap that was raised incrementally and ultimately eliminated), low historical charge data for psychiatric services have had an impact on the BMAD files we used. Also the effective 50% co-payment imposed upon outpatient psychiatric services—through the 62.5% of 80% statutory limit on allowable charges—adds a greater complexity to calculating Medicare allowed charges.

Response: We agree that there are problems with the reporting of psychiatric data in the BMAD files, especially in regard to reporting of statutorily required copayments for outpatient psychiatric services. Therefore, for this final rule, we have generally based practice expense and malpractice RVUs for psychiatric services on inpatient data only (because the 62.5 percent limit does not apply to psychiatric services furnished to inpatients). For psychiatric data with very few services furnished in inpatient settings, we have adjusted our data to remove the effect of the 62.5 percent limit.

[Under-Reporting of Gastroenterology Data in BMAD]

Comment: Some commenters expressed concern regarding the heavy reliance upon the BMAD files for development of practice costs and malpractice components of the fee schedule calculation. For example, some commenters indicated that in a study by the Battelle Human Affairs Research Centers which examined the BMAD files as part of a study of gastroenterologists, it was determined that the BMAD files for gastroenterologists were biased in several States because:

- (a) BMAD does not identify gastroenterologists in multi-specialty groups;
- (b) The data do not include many gastroenterologists who are recorded only as internists; and
- (c) Some carriers do not even recognize the gastroenterology specialty code.

Response: For BMAD reporting purposes, carriers provide information on services and expenditures by physician self-reported specialty codes. These specialty codes for descriptive data reporting purposes should not be confused with carriers' specialty codes for payment purposes. Under the customary, prevailing, and reasonable charge payment system, each carrier has individually developed payment profiles, some of which vary by specialty. Regardless of the specialty differentials used by the carriers for payment purposes in the past, all carriers are required to report BMAD utilization and expenditure data using the standard specialty codes, as self-reported by each physician or group. It is possible that gastroenterologists would be "undercounted" in BMAD if some chose to report their specialty as being internal medicine, for example, rather than gastroenterology. Carriers do not report the specialty of each individual physician in a group. In any case, we do not believe reporting of specialty codes penalizes gastroenterologists. On the contrary, it appears to benefit them because the practice cost percentages we used for internal medicine (46.4 percent) and group practices (50.5 percent) are higher than those used for gastroenterology (40.5 percent). Thus, to the extent there actually was under-reporting of gastroenterologists' services, the practice expense RVUs would be higher for their services.

[Proposed Rule Lacks Critical Data]

Comment: Some commenters indicated that although the proposed rule provides a brief overview of the

data development for the physician fee schedule, it does not include the 1989 fees used to develop the 1991 baseline average historical allowed amounts, nor the 1991 allowed amounts. Therefore, they believe it is virtually impossible to analyze or validate the data adjustments we made. These commenters believe this information is as vital as the GPCIs and RVUs provided in the appendices to the proposed rule, and should be published.

Response: In publishing the proposed rule, we had to use some judgment in determining the detailed data to include. The vast amount of information involved precludes our publishing all detailed data that are potentially useful. In regard to 1989 and 1991 allowed amounts per procedure, although we did not publish our estimates of 1989 and 1991 allowed charges and frequencies per procedure, we made our analytic files available to the public upon request. These files were reportedly used by many physician and professional organizations to compute these data.

[Assumption With Respect to Relative Rates of Increase in Allowed and Prevailing Charges in Data Aging]

Comment: Some commenters believe that in aging data from 1989 to 1991, we assumed that allowed charges increase each year at the same rate of increase as prevailing charges. They indicated that in fact allowed charges increase faster than prevailing charges because, for example, customary charges are not restrained by the MEL. Based on their own analysis of the BMAD files, these commenters indicated that allowed charges increased 3.8 percent per year faster than prevailing charges. Therefore, they believe this differential should be applied as part of the process for aging data to 1991 payment levels. Furthermore, a complete disclosure regarding all adjustments and their underlying assumptions should be made in the final rule, and public comments should be solicited.

Response: Although it is true that we did not provide specific details when we aged our data files in the proposed rule on this issue, we did take into account the fact that allowed charges increase faster than prevailing charges. Generally, we assumed that submitted charges that were below customary charges in 1989 increased by 9 percent between 1989 and 1991—the increase indicated by the consumer price index for physician services. Similarly, we assumed a 9 percent increase for customary charges below prevailing charges for primary care services and a

4.2 percent increase for nonprimary care services below prevailing charges (because these services received no customary charge update in 1991).

A major exception to this methodology was for radiology services where the simulated 1991 average allowed charges were set at the level of the 1991 radiology fee schedule. The methodology for anesthesia services is explained in the section of this preamble pertaining to computation of RVUs for anesthesia codes.

[Use of 1991 CWF Data Rather Than 1989 BMAD Data]

Comment: Some commenters indicated that we should create analytic files using 1991 CWF data rather than attempting to age 1989 BMAD files.

Response: We considered the possibility of using more recent data from the CWF in order to create analytic files on which the fee schedule is based. However, for this final rule, we continued to base our analyses on aged 1989 BMAD data for several reasons, including: CWF is a relatively new data system that has not yet been widely used or validated by analysts inside and outside of the Federal government; and CWF data for 1991 would obviously be incomplete because we needed to develop our initial files for this final rule by mid-year 1991. These data for the first 6 months of 1991 would likely be biased due to a lack of a complete 6 months' reporting, resulting in a possible understatement of the more extensive services. In addition, for 1990, there were only 30 States reporting under CWF for the entire year (for example, there were incomplete CWF data for Florida, Michigan, and California for 1990).

G. Definitions

1. Global Surgery Policy

Each of the Medicare carriers uses the concept of global fees for surgery. However, there are significant variations among carriers as to what periods constitute pre-operative and post-operative care and what specific services are included in these periods. In the proposed rule we said that there is a need for standardization of the global package among carriers, since all carriers will use the same national relative values.

a. *Major surgery.* We explained in the proposed rule that the physician work RVUs in the proposed fee schedule were primarily based on Phase II of the Harvard study. The global surgical service in the Harvard study included pre-operative visits on the day before surgery or the day of surgery, the

hospital admission work-up, the primary operation, immediate post-operative care including dictating operative notes, talking with the family and other physicians, writing orders, the evaluation of the patient in the recovery room, post-operative follow-up on the day of surgery, and post-operative hospital and office visits. The work RVUs for surgical services reflected, to a great extent, the global surgery policy set forth in the proposed rule.

We proposed a uniform, national global surgery policy. We proposed that the initial evaluation or consultation by a surgeon be paid separately from the global surgery package.

We proposed a pre-operative policy that includes all pre-operative visits, in or out of the hospital, by the surgeon from the time of the evaluation/consultation when the decision to have the surgery is made. We proposed a pre-operative period of 30 days.

We proposed that intra-operative services be included in the national global surgery policy. We stated that the global surgery fee would include all additional medical or surgical services required of the surgeon because of complications that do not require additional trips to the operating room. All medically necessary return trips to the operating room, for any reason and without regard to "fault", would be separately billed and paid for, but at a reduced rate. We proposed setting the payment level for re-operations to deal with complications at the value of the intra-operative services being performed if there is a CPT code to describe these services. Codes exist to describe re-operations for complications for various body areas. When no code exists, we proposed to set the payment level at 50 percent of the value of the intra-operative services originally performed.

We proposed a standard 90-day post-operative period that would include all visits by the primary surgeon during this period unless the visit is for a problem unrelated to the diagnosis for which the surgery is performed or is for an added course of treatment other than normal recovery from the surgery.

Phases II and III of the Harvard study provided relative values for global surgery that are based on parameters closely akin to our proposed policy.

[30-Day Pre-Operative Period]

Comment: Many commenters stated that the proposed 30-day pre-operative period was excessive and recommended adoption of a shorter period. The period most often mentioned was 1-day before surgery. The commenters were concerned that the 30-day period would result in initial denials and claims

processing hassles when medically necessary services were furnished within 30 days of surgery, such as a urologist treating a condition medically before resorting to surgery or an ophthalmologist furnishing extensive evaluation services before performing cataract surgery.

Response: This was the predominant comment that we received on the major global surgical policy. Upon further analysis we agree and will adopt a pre-operative period of 1-day before surgery in the global surgical package. We stated in the proposed rule that we would pay for the initial visit/consultation by the surgeon. Our data show that more than one visit is billed by the surgeon in the 30 days before surgery in only a very small percentage of cases. It is likely that many of these visits would be payable as necessary medical treatment in the situations described in the comment. Abuses of this 1-day policy can be controlled by post-payment medical necessity review of pre-operative visits billed by physicians who chronically bill excessive visits. We will carefully monitor pre-operative billings by surgeons and will consider lengthening the global pre-operative period if we detect widespread abuses, for example, significant billings for services 2 or 3 days before surgery. This targeted monitoring, however, is not appropriate for more general review of the volume and intensity of services for which a baseline adjustment is needed.

[Inclusion of Visits by Primary Surgeons]

Comment: Commenters believe that the global fee should not include all visits by the primary surgeon for 90 days after the surgery. Many times, especially in rural areas, a surgeon may also be functioning as a primary care-giver and may be furnishing services during this period unrelated to the surgery.

Response: Primary care services that are not related to the surgery will be paid separately from the global surgical fee. We have developed a new CPT modifier, 24, to facilitate billing and claims processing of these services. The global fee includes only services furnished by the surgeon related to recovery from the surgery.

[Post-Operative Services]

Comment: Commenters noted that all surgeries and all patients are different. Some patients require an extraordinary amount of post-operative care. They believe that physicians should be allowed to charge extra when a patient needs more than the normal post-

operative services when recovering from surgery.

Response: We agree that not all patients require the same amount of post-operative care. While some do require more than the usual amount of care, others require less than the usual amount, and the amount of post-operative care will thus average out over time and patient population. The global surgery RVUs are for the typical patient, and thus are intended to cover both easy and difficult cases. Therefore, paying extra for difficult recoveries would mean overpaying for surgeries on average. However, for very unusual circumstances we have established an "unusual services" modifier that physicians can use to request special carrier review.

[Post-Operative Period]

Comment: Commenters stated that not all surgeries require the same recovery time. The length of the post-operative period should vary by procedure.

Response: We considered this approach. After consulting with our CMDs and the American College of Surgeons, we decided that 90 days is an appropriate period for all major procedures.

[Re-Operations]

Comment: Most commenters supported our policy of paying for re-operations because of complications without regard to "fault" when the services cannot be handled at bedside. However, while agreeing that no additional payment should be made for pre- and post-operative services, some commented that the same amount of work is involved in the re-operation as in the original surgery, and that payment should be at 100 percent rather than at 50 percent of the value of the intra-operative services.

Response: We believe that the intra-operative work involved in most re-operations will be less than in the original surgery. For example, in the case of a bypass surgery it may be necessary to re-operate to resuture only part of a graft to stop bleeding. We will continue to study this issue but will maintain our proposed position of paying at 50 percent of the intra-operative RVUs in the meantime or the value for the operative procedure if it exists. This amount will be more than the amount paid under the current system when many complications were not billed.

[Major Surgery Complications]

Comment: Commenters believe that the major surgery complications policy to pay for complications requiring return

trips to the operating room should be clarified to recognize that surgeries are also performed in ASCs, hospital outpatient departments, and physician's offices.

Response: We agree that procedures subject to our major surgical global policy that may require a re-operation because of complications are also done in ASCs and hospital outpatient departments. We will pay for re-operations in these settings. We do not believe that major surgeries are done in physicians' offices. Surgeries in physicians' offices will most likely be subject to the minor surgical policy. We stated in the proposed rule that we would not pay extra for complications that the surgeon could handle at bedside. We see no difference between the bedside setting and the office setting, and we will not pay extra for complications that are treated in an office setting.

[Organ Transplants]

Comment: Commenters stated that organ transplants require a number of services by a number of specialists. These services are unique to each case, not only in surgical services required but in post-operative care. For example, a transplant surgeon is often involved in managing the post-transplant immunosuppressive therapy, including routine care as well as rejection episodes and care for other conditions such as diabetes mellitus. These services should be paid outside of the global fee for the transplant. Transplants do not fit neatly into a global package concept.

Response: We believe the volume of kidney transplants indicates that they are relatively routine and provides us with significant experience and data with which to set a national relative value. Unusual kidney transplants can be designated with a modifier "22". We agree that at this time other major organ transplants should be individually valued by the carrier. We intend for 1993, however, to establish RVUs for major organ transplants and to seek comment on determining appropriate RVUs. Immunosuppressive therapy will not be included in the global fee, but will instead be paid separately. Work RVUs have been adjusted to reflect this decision.

[Epilepsy Treatment]

Comment: Neurosurgeons specializing in treating epilepsy, called epileptologists, commented that new surgical treatments for epilepsy do not lend themselves to the global fee policy. The patient is admitted to the hospital and electrodes are inserted into the

brain (CPT code 61533). The patient stays in the hospital for about 2 weeks during which time tests are performed to determine the portion of the brain causing the seizures. The electrodes are then removed (CPT code 61535). The patient is discharged, re-admitted in a few weeks, and the epileptic areas of the brain are removed (CPT codes 61510, 61534, 61536, 61539, 61541, 61543). The commenters are concerned that since all the surgeries are done within 90 days of the electrode insertion that the surgeries will not be recognized and paid as separate procedures.

Response: These are clearly distinct procedures and are not re-operations or part of the global fee for the preceding procedure. Each one will be paid separately, and a new 90-day post-operative period will begin with the most recent procedure.

[Global Fee Policy Interferes With Practice of Medicine]

Comment: Some commenters stated that section 1801 of the Act prohibits interference in the practice of medicine and that therefore, we are violating the law by specifying the services and number of visits included in a surgical global fee period.

Response: We do not agree that the creation of global fees for surgical procedures interferes in the practice of medicine and is, therefore, a violation of section 1801 of the Act. We are required by section 1848(c)(4) of the Act to define services for fee schedule payment purposes, and specifically, to define nationally uniform definitions of all services including global surgery for purposes of fee schedule payment. The global fee definition does not in any way restrict the nature of the services furnished or the number of visits the physician furnishes to the beneficiary as part of the global package. Rather, the global fee compensates for the physician's services typically associated with the surgery and is based upon the typical amount of work included in the global period.

b. *Minor surgery and nonincisional procedures.* In addition to the major global surgeries in the Surgery section of the CPT, there are a number of minor surgeries designated by a "star" following the procedure code number. These relatively minor surgical services are not traditionally paid using a global surgery policy.

In addition to major and minor surgeries, the surgery section of the CPT also includes the "scopies." These are diagnostic and therapeutic procedures that are frequently performed by

nonsurgeons and may or may not involve actual surgery.

We proposed for minor surgeries and "scopies" that no visit generally be allowed in addition to the surgical procedure or scopy unless a documented, separately identifiable service is furnished and that post-operative services related to recovery from the procedure be included for a period of 30 days. Services furnished during this 30-day period for treatment of the underlying condition would be paid for separately. The preamble to the proposed rule stated that the minor surgeries and "scopies" that would be included in this policy would be identified in carrier instructions.

[Documentation for a Visit and Minor Procedure]

Comment: Commenters noted that the proposed rule would allow payment for a visit and a minor surgical or endoscopic procedure on the same day only if documented separate and distinct services in addition to the surgery or endoscopy are furnished. While many commenters agree with the policy, they objected to having to submit additional documentation each time they bill a visit on the same day as a minor surgery or endoscopy as merely another increase in the "hassle" factor. Commenters specifically cited minor surgeries such as arthrocentesis and chemotherapy services including thoracentesis and lumbar puncture, which are commonly done during an extensive visit and which are inconsistently handled by carriers. Sometimes both are paid, sometimes the surgery is denied, sometimes the visit is denied.

Response: We do not intend for this policy to be used to hassle physicians. Extensive documentation will not be required with the initial claim. To facilitate billing and claims processing for visits furnished the same day as a minor surgical or endoscopic procedure, the CPT established a new modifier (25) to be used on these bills. We intend to enforce this policy on a postpayment basis by profiling physician billing practices and contacting those physicians who bill excessive visits on the same day as a minor surgery or endoscopy. These physicians will then be required to justify their billings. We believe one major advantage to physicians of implementation of the fee schedule will be more uniform handling of claims by carriers as a result of national standardization.

[Endoscopic Procedures]

Comment: Commenters indicated that endoscopic procedures do not have a

follow-up period and should not be considered global surgery. There is no suture removal, or change in dressing or other post-operative services normally associated with a global surgical period. Any additional services by the physician performing the scopy will be for treatment of the underlying condition or some completely separate condition or for a follow-up scopy.

Response: We received many comments on this issue. Upon further analysis we agree, and there will be no follow-up period for endoscopies performed through an existing body orifice. Endoscopic surgical procedures requiring an incision for insertion of the scope will be covered under either the major or minor surgical policy, depending on the procedure.

[Minor Surgical Procedures]

Comment: Some commenters noted that Harvard did not include any pre- and post-operative services in the work values for minor surgical or "starred" procedures. They stated that these procedures, for example minor dermatological surgeries, should not have a 30-day follow-up global period. Payment for follow-up services should be made separately.

Response: The values in the proposed rule did not contain any pre- and post-operative services for minor surgeries. We have revised our position in this final rule to allow post-operative periods of 0 or 10 days for minor surgical procedures. The list at Addendum B of this final rule indicates which periods apply to which procedures. We have revalued these services to reflect the appropriate revision, and the work values in this rule reflect these revisions.

2. Geographic Payment Localities

Under the present customary and prevailing reasonable charge system of payment for physicians' services, a Medicare locality is the geographic area that the carrier uses to determine the prevailing charges for services. There are presently 240 Medicare localities, which were developed by carriers, based on their knowledge of local medical practice and economic conditions.

Section 1848(j)(2) of the Act defines fee schedule areas as Medicare payment localities. However, recognizing the lack of consistency among current localities and the fact that significant demographic and economic changes may have occurred since the existing localities were established, we are reviewing recommendations on the possible reconfiguration of existing localities. A study was conducted for us

by the UI. Also, Congress required in section 6102(d)(6) of Public Law 101-239 that the PPRC conduct a study to determine the feasibility of using some other configuration, such as States or MSAs, for payment areas under the fee schedule. Both the PPRC and the UI recommended that current carrier localities be replaced with alternative payment areas.

We are still examining these studies. We announced in the proposed rule that the only locality changes we were prepared to make at this time were changes to a Statewide locality in States where overwhelming support existed among both rural and urban physicians for the change. Because we have already received a demonstration of support from physicians in Nebraska and Oklahoma, we proposed that those States be converted to Statewide localities on January 1, 1992, under the authority of sections 1848(j)(2) and 1842(b)(3) of the Act.

GPCIs have been developed and proposed for all existing payment localities. Since a relative value would be computed for every physician service and a GPCI would be available for every locality, a fee schedule amount would be computed for every service for every locality. In the proposed rule we stated that once the initial fee schedule payment areas and their respective GPCIs are established, carriers would not be allowed to modify them.

[Consistency of Localities]

Comment: Many commenters noted that the existing Medicare localities are not established on a consistent basis. Conditions have changed since they were established in 1965. Areas that were rural then are urban now, but are still classified as rural under Medicare. Commenters stated that their area should be included with the neighboring urban locality, which has higher payment levels. The commenters suggested that we set localities on a more rational basis, such as the PPRC recommendation.

Response: We agree that conditions have changed since Medicare payment localities were established. However, except for considering requests for combining existing localities within a State into a single Statewide locality as mentioned in the proposed rule (56 FR 25833), we are not contemplating any locality changes at this time. Other locality configurations would present considerable operational problems in computing transition payment amounts and GPCIs. We are, however, examining the whole question of Medicare localities, including the PPRC's

recommendations, as well as the several options analyzed by the UI. We are supporting further research on these issues.

[States as Single Payment Areas]

Comment: Some State medical societies and individual physicians commented that their State should be a single payment area.

Response: We stated in the proposed rule that we would consider converting to a single, Statewide locality in States if there is overwhelming support among both urban and rural physicians for the change. We received evidence of overwhelming support from both "winning" and "losing" physicians in Minnesota, and will therefore make the change to a single locality on January 1, 1992. We did not receive convincing evidence of support in the other States, where the "losing" physicians in urban areas opposed the change.

[MSAs as Single Payment Areas]

Comment: Physicians in fee schedule payment areas in some MSAs that cross State lines—for example, Cincinnati, Ohio-Kentucky-Indiana MSA, and Davenport, Iowa-Rock Island-Moline Illinois MSA—commented that the MSA should be one fee schedule payment area.

Response: Again, we are presently only considering requests for combining existing localities within a State into a single Statewide locality. We are not at this time prepared to combine parts of existing localities to create new localities that cross State borders. Payment areas utilizing some MSA configurations are among the alternatives discussed by the PPRC and the UI that we are evaluating for possible future changes.

[Locality Changes in Response to Physician Request]

Comment: A commenter applauded our position of making locality changes if overwhelming support exists among affected physicians for the change. The commenter suggested that our ability to be responsive to physician requests for these changes after this final rule is published be guaranteed by including language to this effect in the regulations so that future changes can be made if needed.

Response: We have revised § 415.4(c) to indicate that we can make further locality changes after the fee schedule becomes effective (January 1, 1992). Because of the transition, however, we would be unlikely to consider any locality changes before 1996, except changes involving consolidation of Statewide localities.

H. Adjustments to Fee Schedule Payments

1. Site of Service Differential

We proposed to vary payment based on site of service as follows:

- Services that are primarily performed in office settings when performed in outpatient departments would be subject to a payment limit. For these procedures, we would reduce the practice expense RVU by 50 percent. Payment would be the lower of the actual charge or the reduced fee schedule amount.

- For a specified list of facility-based procedures that are sometimes performed in physicians' offices, physicians would be permitted to bill separately for the cost of a specified list of expensive supplies if those supplies are used to perform the procedure in the office.

We proposed to publish a national list of procedures subject to the site of service limitation, which are performed predominantly (that is, at least 50 percent of the time) in office settings. In the proposed rule, we stated that we are also considering extending this limit to include procedures that are performed less than 50 percent of the time in an office setting but that exceed an annual aggregate volume threshold. Finally, the limit would be applied only to the practice expense RVUs and not the entire payment. The limitation on the practice expense RVUs would reflect lower practice costs incurred in the outpatient department. We would determine the practice expense RVUs according to practice costs incurred in the dominant site-of-service and not the average of practice costs across all settings. We proposed to reduce the practice expense RVU by 50 percent when an office-based service is performed in an outpatient department.

We would also eliminate the current exception to this limit for emergency services. However, services of physicians assigned to the emergency department and who bill for emergency department services (CPT codes 99281 through 99285) would not be subject to the outpatient limit for these services.

[Direct Costs of Furnishing a Service]

Comment: Several commenters stated that the direct costs involved in furnishing a service vary from service to service. One commenter indicated, "while the mean differential is 61 percent, the differential ranges from 8 to 97 percent." Until we are prepared to apply a service-specific (or category of service-specific) limit or revise the current law methodology of determining practice expenses, several commenters

believe a smaller reduction should be applied to the practice expense RVU. Some commenters suggested a 40 percent reduction in the practice expense RVU. Other commenters noted PPRC's research and believe that the 50 percent reduction in the practice expense RVU is arbitrary and inequitable. Some commenters suggested that the outpatient limit will be too large in many instances and will create inappropriate financial incentives to furnish a service in an office when there are valid clinical reasons for furnishing the service in a hospital. Other commenters stated that the outpatient limit under the proposed rule would be greater than under the current payment system for services when practice expense represents a large portion of the total RVU. Other commenters stated that the fee schedule should be incentive neutral to allow for the most efficient use of resources.

Response: We are rejecting these comments for several reasons. While we do not disagree that direct costs may vary by procedure, we do not have detailed cost data for specific services subject to the outpatient limit. The data presented were based only on practice costs in a few multi-specialty clinics for a limited number of procedures. In addition, the 50 percent reduction we proposed is not grossly out of line with the 61 percent average found by PPRC. The 50 percent reduction we proposed is based on an analysis of data from the AMA's Socioeconomic Monitoring Survey. We are currently unable to use the data to apply a service-specific reduction. These data suggest that direct practice expenses average 50 percent of total practice expenses (excluding malpractice).

Additionally, the reduction in payment for the site of service differential will average about 21 percent (practice expenses constitute about 41 percent of the total payment and this will be reduced by 50 percent). This will compare to a 40 percent reduction under current Medicare policy. We do not have evidence that the current outpatient limit has had adverse effects on access to services or quality of care. As the percentage limit under the fee schedule will be less than the current percentage limit, we do not believe the fee schedule policy will have any adverse effects either.

We agree that payment under the fee schedule should be incentive neutral. That is, we believe the physician should select a place of service for valid clinical reasons—not for payment considerations. By not applying a reduction in payment, we would, in

effect, be providing a physician with incentives to use the outpatient department when payment would be the same but direct practice costs would be less.

The outpatient limit under the fee schedule will not be greater than under the current policy for any service. Under current policy, the total payment is reduced by 40 percent. For the total reduction to be greater than 40 percent, the practice expense RVU would have to represent more than 80 percent of the total RVU. There are no professional physician services for which the practice expense RVU represents more than 80 percent of the total RVU.

We disagree that the outpatient limit will penalize a physician who has valid clinical reasons for performing a procedure in the outpatient department. Rather, we believe the outpatient limit will appropriately reflect that the physician incurs fewer costs when furnishing a service in the non-office setting.

[Site-of-Service Differential]

Comment: A commenter suggested that a site-of-service differential should be applied by increasing payment for services furnished in the office and decreasing payment for services furnished in other settings.

Response: For services that are routinely furnished in the office, the practice expense and malpractice RVUs reflect charge data that are largely from the office setting. Consequently, we believe the practice expense and malpractice RVUs for office-based services reflect our best estimate of the resources used to furnish a service in the office. If the service is furnished in the outpatient department, we believe that fewer physician resources will be used to furnish the service and the practice expense RVU will be reduced.

If our understanding of the comment is correct, the intent of the comment is to base the practice expense RVUs on the office or facility site only—whichever predominates and increase the RVUs for practice expense and malpractice for services that are commonly furnished in a hospital, ASC, or other facility if these services are performed in an office setting and decrease the practice expense RVUs if office-based procedures are performed in facilities. On the surface, we believe this idea is an interesting concept for two reasons: (1) It recognizes higher practice costs for services performed in an office setting, and (2) this differential could encourage the movement of services out of a facility setting into the lower cost office settings. We are concerned, however, that this would

need to be done selectively so as to avoid encouraging the movement of services to office settings that might not be appropriately performed outside of a facility, thus raising questions of safety and quality of care. We are concerned primarily about surgical procedures for which questions of quality would be most profound. For most diagnostic services, we do pay an additional technical component for services in physicians' offices. Except for procedures for which we will pay extra for supplies, we cannot now identify procedures for which higher practice costs should be recognized in office settings that do not present this quality of care issue. Nevertheless, we believe the method of allocating practice expense allowances requires continuing study and analysis, and we will continue to explore and welcome public comments on this issue.

[Savings for Reductions in Payment]

Comment: A commenter suggested that the proposed rule is silent on whether the savings from reductions in payments for the site of service differential are used to increase the practice expense component for office-based services or they are added to the physician work component for all services.

Response: We did neither. There were no "savings" from establishing a site of service differential because all the relative values were taken into account in computing the overall CF. We have not completed a detailed impact analysis of this issue, but this payment reduction policy may represent a cost rather than a savings because, compared to current policy, the magnitude of the payment reduction is less. However, because the current policy is implemented at the carriers' discretion, and the fee schedule policy will be implemented uniformly nationwide, the policy may generate savings by applying it to more services. Relative to not applying a differential at all, this policy generates savings that we used to increase the overall CF.

[Outpatient Limit on Emergency Services]

Comment: Some commenters stated that the outpatient limit should not be applied to emergency services. According to these commenters, the current outpatient limit excludes emergency services so the exception should be maintained under the fee schedule. Other commenters supported an exemption for emergency department visits (CPT codes 99281 through 99285) but noted that there is no reference exempting these services in § 405.502.

They urged us to make specific reference to an exception for emergency department visits in the regulation. Other commenters urged us to maintain the exception when emergency room services are furnished in conjunction with an emergency department visit service. According to these commenters, the practice expense RVUs would already reflect practice expenses for emergency medicine physicians.

Response: Under the outpatient limit, there is currently an exclusion for services considered to be true "emergencies." We do not believe maintaining the emergency exception is appropriate under the fee schedule since the intent is to base payment on average resources. The reduced physician practice expense for a service performed in a hospital outpatient department will apply whether or not a service is an emergency. Moreover, emergency department visit services (CPT codes 99281 through 99285) are, by definition, excluded from the site of service differential.

The outpatient limit will only apply to services that are on our list of office-based procedures. As we stated above, emergency department visits, by definition, are excluded from the limit. Consequently, emergency department visits will not be on our list and will not be subject to a limit. Specific reference in the regulations is not required.

With regard to allowing an exception if office-based services are performed in conjunction with an emergency department visit, we do not believe an exception would be appropriate. The practice expense RVUs for office-based services will reflect practice expenses in the office only. The limit will be necessary to appropriately reflect reduced practice expenses when the service is furnished in the outpatient department regardless of whether the service is performed in conjunction with an emergency department visit.

[Outpatient Limits and Office-Based Procedures]

Comment: Some commenters objected to the outpatient limit as an unfair burden on practitioners who typically perform office-based procedures in an outpatient setting. According to these commenters, the outpatient limit does not take into account the wide variation in practice situations (that is, a physician may not have access to emergency support making the service unsafe to perform in the office). Additionally, in some areas the outpatient limit may penalize a physician when he does not have the capacity to perform the procedure in an

office. These commenters prefer that we develop RVUs based on office or non-office practice costs.

Response: We do not believe the outpatient limit is unfair to physicians who typically furnish office-based procedures in an outpatient setting. Nor do we believe that the outpatient limit penalizes physicians who do not have the capacity to perform a procedure in the office. As the practice expense RVU is based on charges in the office setting, the reduction merely reflects that physicians furnishing services in the outpatient department use fewer resources to furnish a service.

[Standardization of Outpatient Limits]

Comment: Some commenters expressed support for our efforts to standardize our policy regarding the outpatient limit. These commenters believe the outpatient limit under the current payment system is inconsistent between carrier areas. Additionally, these commenters believe we should stress that carriers only apply these limits when an office-based procedure is performed in a hospital outpatient department. The policy should not be applied when office-based services are performed in ASCs or procedures on the ASC-list are performed in hospital outpatient departments.

Response: We agree that the outpatient limit is inconsistently applied at the present time. Under the fee schedule, we are establishing a listing of procedures subject to the site of service limit. Also, at this time we will not apply the limit if office-based procedures are performed in ASCs.

[List of Services Subject to the Outpatient Limit]

Comment: Some commenters stated that a list of services subject to the outpatient limit was not provided. These commenters believe we should consult with specialty societies and publish a proposed list for examination and comment. Additionally, other commenters would like us to publish a statement of the impact of applying the limit to the proposed list of services.

Response: We have provided the list of services subject to the outpatient limit in Addendum F.

[Volume Threshold Criterion]

Comment: Some commenters expressed concerns about our applying the limit to services that are not furnished 50 percent or more of the time in the office but meet a minimum volume threshold. According to these commenters, the volume threshold criterion would subject consultations to the limit when these services have

legitimate practice expenses in both the office and hospital setting. Additionally, some commenters are concerned that the volume threshold criterion could give us broad authority to expand procedures subject to the limit. These commenters urged us not to consider a minimum volume threshold criterion for determining our list of procedures.

Response: At this present time, we are not expanding the list of office-based procedures to include services that meet a minimum volume threshold.

[Technical Components for Gastrointestinal Endoscopy]

Comment: Some commenters expressed support for recognizing a technical component for gastrointestinal endoscopy. These commenters believe that there are significant additional costs for ancillary personnel, equipment, and drugs associated with office endoscopies that should be recognized in the payment system.

Response: We do not currently pay a separate technical component for endoscopic procedures. Generally, a technical component is recognized only for services that involve a diagnostic procedure that is separable from the physician's service. That is, a technician can perform the diagnostic procedure, and the results are interpreted by the physician. In the case of endoscopic procedures, the physician's service is not separable from the "diagnostic" procedure. For endoscopic procedures that are performed primarily in office settings, practice expense is based solely on the allowed charges in office settings. Thus, to some degree, we do recognize the higher practice expenses associated with office-based procedures to the extent that higher costs are reflected in charge patterns. Other endoscopic procedures are judged safe to be performed only in an ASC or hospital. For these procedures, we do not think a technical component cost should be recognized. Nevertheless, we believe, as we have indicated earlier that the whole issue of practice expenses requires considerable further consideration and analysis.

[Directions for Carriers for Outpatient Service Payment]

Comment: Some commenters are concerned that the proposed regulations do not include directions for the carriers on determining payments for outpatient services.

Response: We have added a new § 415.32 regarding determining payments for certain physician services furnished in outpatient hospital settings. Specific directions for the carriers will be

included in the Medicare Carriers Manual.

[Procedures Subject to the Outpatient Limit]

Comment: Some commenters expressed concern about the arbitrary nature of our criteria for selecting procedures subject to the outpatient limit. According to these commenters, there will be many communities where the procedures subject to the limit are not furnished in the office 50 percent or more the time.

Response: Physician payment reform is intended to establish consistent policies as well as payment equity. Under the fee schedule, we are attempting to establish national policies that will be implemented uniformly. As the practice expense RVU is based on the national average allowed charge, we believe it is appropriate to select the procedures subject to the outpatient limit based on national data regardless of local practice.

[Application of Outpatient Limit in Certain Situations]

Comment: Some commenters raised questions about whether the outpatient limit would be applied in certain situations. For instance, a group practice may own an immediate care center physically located in a hospital or several satellite clinics. These commenters were concerned that the outpatient limit might apply when the service is furnished in these facilities. The commenters requested clarification regarding whether the outpatient limit would apply in these situations.

Response: We would need further information to give a definitive answer. Generally, office-based services performed in an outpatient hospital setting will be subject to the limit except in limited circumstances such as when an independent practice was merely leasing space in an outpatient hospital setting but not utilizing hospital staff or other resources.

[Increase in Overall Health Spending]

Comment: Some commenters stated that overall health spending could increase under our proposed policy because physicians would purchase expensive equipment that is already provided by hospitals.

Response: We believe the payment differential is incentive neutral with regard to selecting a practice site. That is, we do not believe the outpatient limit will induce physicians to purchase additional equipment to enable them to furnish services in the office.

[Practice Expense Variation]

Comment: Some commenters believe that most practice expenses do not vary depending upon the site where a service is performed. According to these commenters, the outpatient limit would create a disincentive to provide high-risk patients with care in the most appropriate setting.

Response: Again, we believe practice costs for services do vary by site of service, and the outpatient limit will be established to make physicians neutral in selecting a practice site. Consequently, we do not believe the outpatient limit will create a disincentive to treat high risk patients in the most appropriate site.

[Limitations in Observation Units]

Comment: Some commenters are concerned that the limit will be applied by carriers to services furnished in an observation unit of a hospital. These commenters urged us to recognize observation unit charges as comparable to other hospital visit or consultation services that will not be subject to the outpatient limit.

Response: We do not consider these to be hospital visit services because the patient is not admitted. Furthermore, we have no way of distinguishing between these visits and hospital outpatient visits when the outpatient limit should apply.

[Elimination of the Outpatient Limit]

Comment: Some commenters believe staff involved in direct patient care are employed regardless of whether a physician performs a procedure in the office or hospital. Consequently, according to these commenters, a physician would still incur costs when office services are furnished in a hospital setting. For this reason, commenters support eliminating the outpatient limit.

Response: If we are correct in our understanding of the comment, these commenters contend a physician's office staff involved in direct patient care would be employed regardless of where the physician furnishes a service. Therefore, the commenters believe the physician's nonphysician personnel expenses would not be reduced when a service is performed in the non-office setting. We disagree. We believe that the typical physician will furnish services in both office and non-office settings and will employ staff involved in direct patient care only to the extent that they are needed to assist with office services.

[Psychotherapy and the Outpatient Limit]

Comment: Some commenters are concerned that psychotherapy services would be subject to the proposed limit because they are routinely furnished in the office but are frequently furnished in the outpatient department. These commenters do not believe psychotherapy services should be subject to the outpatient limit.

Response: Psychotherapy services will not be subject to the outpatient limit. This is principally because of continuing concerns about the adequacy of BMAD files used to compute practice expense levels for these services.

2. Professional/Technical Component Services

a. *Radiology services.* The global RVU would be the sum of the professional component and technical component RVUs. We proposed that the professional component RVU from the existing radiologist fee schedule be divided into physician work, practice expense, and malpractice components for the purposes of rescaling and applying GAFs.

Under the proposed policy, practice expenses for technical component services would be treated essentially as practice costs are treated for all other physician services. That is, the technical component RVUs under the fee schedule would be equal to the estimated average allowances for each technical component service based on the radiologist fee schedule.

[Cost of Compliance With Safety Regulation]

Comment: Some commenters stated that nuclear medicine, a subspecialty of radiology, has many fixed costs associated with safety and environmental regulations. According to these commenters, the technical component fees in the proposed rule would not cover practice expenses for nuclear medicine procedures. They recommend that cost data be regularly updated to reflect dramatic cost changes.

Response: The law requires the Secretary to review and make adjustments in the RVUs periodically and no less often than every 5 years. We agree that our practice cost data should be updated regularly to accurately reflect the cost of furnishing services.

We disagree that the technical component fees will not cover practice expenses for nuclear medicine procedures. For nuclear medicine services, similar to other radiology services, we divided the technical

component RVU into practice expense (94.1 percent) and malpractice expense (5.9 percent) based on the average practice expense percentages for radiologists who do own equipment. (The work percentage is 0 because the technical component does not involve a professional physician service). We then multiplied the practice expense and malpractice portion of the technical component RVU by the national average CF used in 1991 under the radiologist fee schedule. To the extent that the radiologist fee schedule CFs were reduced as a result of legislation, the technical component RVUs under the physician fee schedule reflect what would have been paid under the radiologist fee schedule. We believe Congress intended to reduce radiology fee schedule CFs to reflect overpricing. Consequently, we do not believe payment for technical component services under the physician fee schedule is insufficient to reflect prior adjustment for practice expenses.

b. *Diagnostic tests*—(1) *General.* Our proposed definition of a "diagnostic test" included the following three criteria:

- The service is diagnostic as opposed to therapeutic in nature.
- The physician's professional service is separable from the technical component of the test. This means that the professional diagnostic service is not so integrally related to the performance of the test so as to make separation a practical impossibility.
- Physicians have traditionally separated the professional and technical components of the service for billing purposes.

Under the proposed rule, the professional component RVU would be the Harvard physician work RVU plus practice expense and malpractice RVUs based on current average allowed charges. The relative value for the technical component would be based on the difference between the average allowed charge for the global service and the average allowed charge for the professional component. For services that do not have a professional component (for example, the various audiologic function tests, 92551 through 92589), the RVUs would be based on the average allowance for the service itself. Finally, for diagnostic services for which there is no reliable technical component charge data (for example, cardiac catheterization), the RVUs would be derived through alternative means.

For diagnostic tests without a professional component (for example, audiology and allergy testing), we proposed to classify them as a technical

component only service without physician work (subject to the practice expense and malpractice GAFs only).

[Technical Component RVU Values Not Provided in Proposed Rule]

Comment: Some commenters remarked that technical component RVU values were not provided for some diagnostic test services in the proposed rule.

Response: We explained in the preamble to the proposed rule that there were some situations in which computing technical component values by subtracting professional allowed charges from global allowed charges produced anomalous results. We acknowledged the difficulty of creating technical component values for some diagnostic test services and invited comment on the best method for developing values. No specific methods were suggested. Therefore, we developed an approach for this final rule in which the technical component RVU value will be computed as the difference between the global value and the professional component value only if:

- (1) There is a substantial volume of services in either the global or professional service; and
- (2) There is at least a 21 percent difference between the global and professional component average allowed charges.

If these two criteria are not met, in most cases we will use an alternative formula that is based on the actual charge data for the component with the highest volume of services (and presumably the most reliable charge data), and the assumption that the technical component value is 21 percent of the global value. As part of the outpatient limit analysis (described elsewhere in this Summary of Analysis of Comments and Responses), we have determined that by reducing the practice expense RVUs of the specified services by 50 percent (to account for practice expense costs that a physician does not incur when using a hospital department), we are on average reducing the global fee by approximately 21 percent. If the office or global site has the highest volume and, therefore, is assumed to have the most accurate charge data, then the professional component is assumed to be equal to 79 percent of the global average allowed charge and the technical component is 21 percent of the global charge. If the non-office or professional component site has the highest volume and, therefore, is assumed to have the most accurate charge data, then the technical component value is computed as 27

percent of the professional component value (or .21/.79 times the professional component value).

[Computing RVUs for Audiology Services]

Comment: There is a zero work value in the audiology codes. These services involve considerable work by the audiologist, which commenters believe should be recognized and paid. Also, commenters believe that the percentage relationship of the components of the RVUs should be based on actual data collected from audiologists, and not data from physicians.

Response: We did not mean to imply that audiology tests do not involve work by the audiologist. Audiology tests are covered under the diagnostic test benefit; therefore the services of the audiologist will be covered only as part of the test, and their services will not be paid separately under the fee schedule. For purposes of the fee schedule, audiology tests are considered to be all technical components, thus no work RVUs are shown. Although the proposed rule only shows RVUs for practice expenses and malpractice, the work of the audiologist is included in these RVUs, since they were based on the total charges for the service, which presumably include the work of the audiologist.

Audiologists were not surveyed in determining the percentage relationship by specialty of the three RVU components. Like all specialties for which we did not have data, they were given the percentage relationship between components averaged across all physician specialties. We welcome and would review any data concerning the ratio of practice expenses to malpractice expenses for audiology services that we might use in future years to refine these components.

[Diagnostic Median Caps for Technical Components]

Comment: We have received numerous comments about a specific provision of Public Law 101-508 which mandated that we calculate a payment limit on the technical component of certain high volume diagnostic tests. Commenters generally believe that we did not calculate the payment limits correctly for 1991 and this affects the RVUs for these services on the physician fee schedule.

One code—93736 (pacemaker monitoring-telephone analysis)—was of overwhelming interest to commenters. Several large suppliers of these services have done analyses of our methodology for calculating the median cap and they have identified, in their judgement,

flaws in our approach to the calculation. In general, they argue we have omitted sites of services other than hospitals and physicians' offices in calculating the median. They say our results have produced aberrant results, such as negative, zero, and extremely low technical components. In addition, they have argued that we should have considered local codes in our calculation of the median cap for code 93736.

Response: Section 4108 of Public Law 101-508 provided that payments for the technical component of certain high volume diagnostic services (other than clinical diagnostic laboratory tests and radiology services, including portable x-ray services), which the Secretary must designate, must be limited by the national median of charges for these services. We determined that 19 tests fell into this category and calculated the limit along the median as specified in the statute.

There was a limited lead time provided between enactment and the effective date of January 1, 1991. Consequently, our ability to analyze the data used to calculate the median caps was limited. The statute requires us to make our estimate of the national median using the best data available. We believe we have met this requirement within the time frame available to us. Since there is a limited amount of "technical only" billing, we concluded that for almost all codes, the technical allowances need to be derived by using the billings for the global service and subtracting the professional component billings to arrive at the imputed technical component value. For two codes (93225 and 93226), we used data derived from technical component only billings. Our experience with the BMAD files during the early work on the radiology fee schedule showed that there was a lack of uniformity among the carriers in using the CPT modifier 26 (professional component billing) to identify professional component billings. Therefore, if the place of service for the test was "office," and there was no professional component modifier (26), we concluded that the billing was global. If the place of service was hospital (inpatient or outpatient), the billing was professional component. Using these criteria, we calculated a technical component from the 1989 BMAD files by subtracting the professional component average allowed charge from the global average allowed charge for each carrier locality. We computed the median of these technical components, weighted by the number of services furnished and

adjusted it by the applicable increase for 1990.

We have reviewed the organizations' conclusions about our methodology and we agree with them that we did exclude all sites of service other than "hospital" and "office". Also, our approach of calculating an average allowed charge for the technical component for each carrier locality produced negative, zero, and very low technical components. Since we computed a median, these aberrant values did not have the same effect as if a mean charge was calculated. We also agree that we did not consider local codes. We checked the BMAD files using information provided by the major suppliers of this service and found that local codes largely in two carriers substantially increased the number of services accounted for by the national CPT code. We received no comments about local codes for any other service subject to the median cap other than 93736.

As a result of these comments, we have recalculated the median caps by making the following adjustments:

- All sites of service were considered. To describe the professional component of the service, we used the CPT modifier as used in the BMAD files plus any services furnished where the site of service is inpatient hospital or outpatient hospital. If the claim had no 26 or technical component modifier and the service was performed in a hospital setting, we considered it a global billing.

- We calculated a median, weighted by services, for the global billings and a separate weighted median for the professional component billings. We subtracted the two medians to arrive at a technical component median. We did not calculate a median for each carrier locality. Therefore, we had no negative or zero results.

- For the pacemaker monitoring code, 93736, we added the local codes into the system and used the revised data to calculate the median cap for the code.

We used these recalculated median caps to determine the technical component relative value for these 19 services.

(2) *Electrocardiograms*. Section 4109 of Public Law 101-508 provides that effective with services furnished beginning January 1, 1992, separate payment can no longer be made for the interpretation of EKGs that are performed or ordered to be performed as part of or in conjunction with a visit or consultation. CPT codes 93000, 93010, 93040, and 93042 are covered under this provision. We would establish relative values for EKG interpretations under these codes because of the possibility that a situation would be presented that

involves the separate interpretation of an EKG not related to a visit. We would still pay for the interpretation of very specialized EKGs under other codes not included within the scope of the statutory provision.

We proposed to incorporate additional RVUs into selected visit codes to reflect the resources used in furnishing EKG interpretations.

[EKG Interpretation]

Comment: Some commenters stated that our interpretation of the Public Law 101-508 provision banning payment for interpretation of an EKG ordered or performed in conjunction with a visit or consultation exceeded Congressional intent. According to these commenters, the Conference Report accompanying the law (H.R. Rep. No. 964, 101st Congress, 2nd Session (1990), pp. 734, 736, 738.) clarified that Congress intended the provision to only prohibit payment for the interpretation when the interpreting physician is also the ordering physician. These commenters believe Congress did not intend for the law to prohibit a physician from billing for an EKG interpretation when he or she did not order the test.

Response: We believe the statute supports our interpretation. The statute prohibits separate payment for EKG interpretations that are "performed or ordered" as part of or in conjunction with a visit or consultation. We do not believe the legislative history contradicts this interpretation.

[Underpayment for EKG Interpretation]

Comment: Some commenters stated that our proposed policy of adding RVUs to the visit and consultation services to account for EKG interpretations would be inequitable. According to these commenters, our proposed policy would severely underpay those that do EKG interpretations (that is, cardiologists, internists) and provided unearned payments for other specialties that furnish visits but do not interpret EKGs.

Response: As the statute prohibits separate payment, we have very little flexibility for recognizing the value of EKG interpretations. We believe our only option for recognizing its value is to add work relative values to the visit and consult services. While we do not disagree that adding the RVUs to the visit and consultation services provides payments to physicians performing visit services without doing an EKG interpretation, we have no other way of compensating physicians who furnish this service.

(3) *Technical component of cardiac catheterization services*. Cardiac

catheterization services, in the past, have been performed almost exclusively in the hospital setting. With some exceptions, only a professional component billing has been necessary for payment to be made to physicians. However, cardiac catheterization procedures can be covered in free-standing facilities if, in consultation with the appropriate PRO, they can determine that the services can be performed appropriately and safely in the facility. In the proposed rule, we suggested two methods of establishing an inherently reasonable allowance for the technical portion of the diagnostic catheterization procedures. We found that there was a wide range of payments being made by the carriers and that they used several variations on our payment guidelines to develop the Medicare payment amount for the technical component.

We believe that the number of procedures done in free-standing cardiac catheterization facilities will increase; therefore, there is a need to establish a technical component value for the service. We proposed to use data taken from outpatient hospital bills to calculate the estimated cost for cardiac catheterization furnished in the hospital outpatient department and to use these costs as the technical component for cardiac catheterization services. We proposed to apply the average cost to charge ratio for the hospitals if these services are performed to arrive at a national average cost for cardiac catheterization.

Comment: Commenters generally agreed that there were widespread differences in the way the Medicare carriers were developing payment rates for cardiac catheterization procedures furnished in free-standing facilities. Some commenters objected to our use of hospital outpatient bill data to calculate a payment rate for cardiac catheterization services. They cited several problems, including the lack of recognition of patient volume in calculating an average cost. The second problem cited was the wide disparity in labor costs and other costs. One commenter suggested, based on a detailed analysis of costs, that if 500 procedures were done in a cardiac catheterization facility, \$2,260 would be the average cost for each procedure.

Response: The use of hospital outpatient billing data is, we believe, a reliable measure of the costs of furnishing cardiac catheterization procedures. The calculation of the costs is not based on a division of total costs by volume of procedures furnished. The calculation of costs is based on the

charges on the outpatient bills. The hospital costs are accumulated within revenue centers and account for all outpatient volume, including non-Medicare patients. The billed charges for the services are adjusted to costs by applying the cost to charge ratio for the revenue centers used to accumulate the costs. In addition, by using the GPCI applicable to the area where the hospital outpatient department is located, we are able to adjust individual provider cost data to reflect geographic differences in costs.

We reviewed hospital outpatient bills from about 900 providers for the period July 1, 1990 through June 30, 1991. We removed outliers and any bills when there were more than two cardiac catheterization procedures on the same bill. This resulted in data from about 22,000 bills. Using the general and specific revenue centers associated with cardiac catheterization procedures, we will pay for cardiac catheterization based on the median of hospital outpatient costs, net of the 10 percent capital cost reduction and the 5.8 percent, other than capital cost reduction. We grouped the 16 different cardiac catheterization codes into 5 groupings. We calculated a cost for the grouping using all of the billing data for the codes within each grouping. The following are the groupings used:

Group 1—93501

Group 2—93510; 93511; 93514

Group 3—93524; 93526; 93527; 93528; 93529

Group 4—93546; 93547; 93548; 93549; 93550

Group 5—93552; 93553

The RVUs for the technical component for the codes in the above groups are shown in addendum B of this final rule.

c. Physician pathology services. In the absence of alternative data upon which to base a technical component value, we proposed to assume that the technical component of physician pathology services would be equal to 15 percent of the 1991 adjusted historical charge (as assumed by Congress in section 4104(a) of Public Law 101-508).

[Technical Component Determination]

Comment: Commenters objected to the proposed method to determine the technical component of surgical pathology services.

These commenters remarked that the proposed method under which the technical component is computed as 15 percent of the professional component allowed charge for hospital pathologists undervalues the service. The CAP engaged Abt Associates to conduct a

study on the practice cost percentages for hospital pathologists and independent laboratories. Abt collected data on practice costs from a representative sample of hospital pathologists and independent laboratories. This study concluded that the practice expense component for independent laboratories engaged in both clinical and anatomic services is 83.8 percent. For anatomic pathology services only, the practice expense component is 65.1 percent. The practice expense component for hospital pathologists engaged in both clinical and anatomic services is 33.4 percent. As a result of this study, the CAP recommended that the technical component be established at 35 to 50 percent of the professional component prevailing charge. (The 50 percent practice cost payment amount, for example, is based on the difference between Abt's practice expense component of 83.8 percent for independent laboratories and their practice expense of 33.4 percent for hospital pathologists.)

The proposed rule suggested a practice expense component of 28.5 percent for hospital pathologists. This practice expense percentage is from the AMA's 1989 Socioeconomic Monitoring System Core surveys. Commenters believed that the Abt data more accurately represent pathologists' practice costs because the Abt survey instrument was designed specifically to capture costs incurred by pathologists; whereas, the AMA survey instrument is, of necessity, general to all specialties. For example, the Abt survey instrument explicitly asked for billing expenses including payments to a billing service. The AMA asks more general questions about office expenses, nonphysician payroll expenses, and other expenses. Accuracy of data on this expense category is particularly critical to pathology because a significant portion of hospital-based physicians' practice costs are attributable to billing expense. These commenters recommended that the Abt practice expense percentage of 33.4 percent for pathology be adopted for use in implementing the fee schedule.

Response: For purposes of uniformity and consistency, we believe it is preferable to use a single reliable data source to establish work, practice expense, and malpractice expense percentages. The AMA's 1989 practice cost survey serves this purpose. If we do not use a single data source, some costs could be reflected for some specialists but not for others. We also believe that if, in the future, we continue to use the AMA's practice cost survey, the AMA can coordinate its survey with those

specialties who believe that the AMA's data source is not fully satisfactory. Also, we note that, for pathology services, the more relevant practice expense, also included in the Abt study, is the practice expense for pathologists engaged in anatomic pathology services. In the Abt study, the mean practice expense percentage for anatomic pathologists is 30.2 percent, and the standard error is 2.2 percent. Thus, the AMA's practice expense for anatomic pathologists is within one standard error of the Abt sample practice expense for anatomic pathologists. Therefore, we are continuing to use the AMA's practice expense percentage for anatomic pathologists.

We have also decided not to adopt the practice cost payment amount recommended by the CAP based on the Abt study for several reasons. While the study suggested that the technical component practice cost payment amount for pathology services understates the practice expense component of independent laboratories, it does not demonstrate that the payment will not cover the independent laboratory's cost of performing the technical component. Also, while we have referred to this as a 15 percent practice cost payment amount, when the practice and malpractice expense components of the professional component are considered with the practice and malpractice components of the technical component service, total practice and malpractice expense comprise approximately 53 percent of the total RVUs for the combined professional and technical component services. Moreover, we note that under the reasonable charge system, in most carrier areas, payment for the global anatomic pathology service furnished by independent laboratories was equal to or lower than the professional component service furnished in a hospital laboratory.

[Technical Component Allowances]

Comment: Commenters inquired whether the technical component allowances would apply when a hospital furnishes the technical component of a surgical pathology service to a nonhospital patient.

Response: If the hospital laboratory furnishes surgical pathology services to nonhospital patients, the hospital is acting as an independent laboratory. Since the independent laboratory is paid a technical component fee for surgical pathology services to nonhospital patients, the hospital laboratory will be paid similarly for the technical service

of surgical pathology services to nonhospital patients.

3. Payment Modifiers

a. *General.* We proposed that only modifiers for which we would establish a national payment policy would affect payment. If there were no national payment policy governing the use of a modifier, there would be no differential payment based on the presence or absence of that modifier. However, under the proposed rule, carriers could continue to use local modifiers if they were used for purposes other than payment (for example, utilization or medical review screening).

[Impact of Modifiers on Payment]

Comment: Commenters stated that our proposed policy regarding the impact of modifiers on payment was confusing. They indicated that we should clearly state which modifiers must be used when the circumstances apply (for example, the global surgery split), which modifiers may be used at the physician's or carrier's discretion, if appropriate (for example, reduced services), and which modifiers may never be used for payment or other purposes.

Response: We agree that there is a need to be more specific with regard to when modifiers must, may, and may not be used and the impact they may have on payment. We will create and issue a list in the Medicare Carriers Manual to ensure national standardization of carrier application of these policies to the extent standardization is possible.

[New Modifiers for Global Surgery]

Comment: Commenters to the proposed policies for global surgery and minor surgery believe a requirement to submit documentation to receive payment for visits during the global period unrelated to the procedure would be an additional burden. (See the section of this preamble dealing with global surgery for further discussion.)

Response: Under the global surgery policy, we will pay separately for services or procedures that are unrelated to recovery from surgery during a post-operative period; separately for re-operations because of complications that require a return trip to the operating room; and for a visit on the same day as a minor surgery or endoscopy if documented separately identifiable services are furnished.

The CPT Editorial Panel has established four modifiers to both enable us to better implement this policy and also to reduce the documentation and burden on physicians.

Modifier 24—Unrelated evaluation and management service by the

same physician during a post-operative period. This modifier will be used to indicate that an evaluation and management service was performed during the post-operative period that is not related to the prior procedure.

Modifier 25—Significant, separately identifiable evaluation and management service by the same physician on the day of a procedure. This modifier will be used to indicate that on the day a procedure or service that is identified with a CPT code was performed, the patient's condition required a significant, separately identifiable evaluation and management service above and beyond the usual pre- and post-operative care associated with the procedure or service that was performed.

We expect these two modifiers will simplify billing for physicians and enable carriers to:

- Allow separate payment for these visits without the burden requiring and examining extensive documentation upfront;
- Deny separate payment for visits billed without a modifier; and
- Conduct postpayment monitoring on the use of the modifiers to identify potential abusers.

Until we acquire some experience with modifier 24 billings, we intend to require that documentation be submitted with the modifier before we pay for these services. This will enable us to analyze the frequency with which these services could expect to be paid and therefore set a standard for future payment based on actual experience. We might consider dropping the "up-front" documentation requirement after we are satisfied that we have sufficient experience to develop criteria to identify excessive modifier 24 billings.

We would *not* expect to see modifier 25 billings if a procedure, for example, a minor surgery or a colonoscopy, was scheduled after an examination during a prior visit. We expect that the significant evaluation for the procedure will be performed and paid for as part of this prior visit. We have already added substantial pre- and post-operative work specific to the procedure (record keeping, counseling, prescribing recovery therapy, etc.) into the value for the procedure. Any modifier 25 billings for unrelated evaluation and management services must be for services *not* provided during either the procedure itself or a prior visit.

Modifier 78—Return trip to the operating room for a related procedure during a post-operative

period. This modifier will be used to indicate that another procedure was performed during the post-operative period of a related procedure.

Modifier 79—Unrelated procedure by the same physician during a post-operative period. This modifier will be used to indicate that the performance of a procedure or service during a post-operative period was unrelated to the original procedure.

We expect these two modifiers will simplify billing for physicians and enable carriers to:

- Allow separate payment for surgical procedures unrelated to complications from the original surgery, which are performed during the post-operative period of another major surgery;
- Allow separate payment for treatment of complications during the post-operative period, which requires a return trip to the operating room; and
- Deny separate payment for treatment of complications, which do not require a return trip to the operating room and are billed without the modifier.

While the use of these four new modifiers is intended to facilitate claims processing by identifying which services should be paid and which should not be paid, it does not mean that their use automatically means that carriers will assume that all such services are medically necessary and payable. In using the modifier, the physician is certifying that the services meet the requirements for the specific modifier. Through use of the new comparative performance reports and other payment safeguards, carriers will be required to identify any excessive use of these modifiers. Additional documentation may be requested from physicians disproportionately using these modifiers and physician audits initiated where necessary. Any identified abuses could subject physicians to overpayment refund requests, closer prepayment scrutiny, and possibly fraudulent billing penalties.

[Additional Payment for CPT Codes That Act as Modifiers]

Comment: Commenters objected to our proposal not to permit additional payment for the following CPT codes that act as modifiers:

- "After hours" services (codes 99050 and 99052)
- Prolonged physician attendance (codes 99150 and 99151)
- Extra supplies and materials (code 99070)

Commenters indicated that each of these codes or modifiers represents

additional resources to the physician that are not being otherwise compensated.

Response: We believe that most physicians typically see a mix of patients during a year, that is, some patients require more than average resources and some require less. Fee schedule payments are based on average or typical resources required to furnish a service. We do not believe it is desirable to establish a nationally uniform payment system that allows for many opportunities for physicians to routinely circumvent the standard payment amounts. However, recognizing that unique circumstances can occur, we do allow for extra payments through the use of the unusual services modifier (CPT modifier 22) with supporting documentation.

[Creation of a Special Modifier]

Comment: Commenters indicated that a special modifier should be created and the service paid when the patient has disabling cognitive or physical impairments or an unusual need for counseling or coordination of care.

Response: Although commenters were not specific about whether they intended this modifier to be used for all codes or only for visits, we believe that they intended that it be limited to visits. The PPRC visit coding recommendation included an automatic upcoding of one level for individuals with these special characteristics.

We do not believe that it is necessary or desirable to create this modifier to ensure that payment reflects the work in a visit. It would be difficult to operationally define "disabling or physical impairments" and validate that these impairments actually required additional physician work for a given service. It would certainly be undesirable to establish criteria for the use of this modifier in a way that required additional testing or services merely to establish that use of the modifier is justified. We believe that most physicians see a mix of patients and that they will not be adversely affected by a payment system established on the basis of averages.

Furthermore, we believe that the visit level definitions will enable a physician to code properly visits with individuals with these impairments to the extent that these impairments increase work in a visit. Counseling and coordination of care are factors explicitly addressed in the visit codes.

[Exempt Kidney Transplants From Modifier Policies]

Comment: Commenters believe kidney transplants involve unique team

services and should be exempt from the modifier policies and should each be priced separately upon examination.

Response: While we have RVUs for a kidney transplant, we agree that unusual circumstances may arise. CPT modifier 22 may be used to indicate unique circumstances.

[Creation of a Modifier for Unusually Difficult Cases]

Comment: Commenters indicated that we should create a modifier that would be used in unusually difficult cases, much like the payment for outliers that the DRG payment system provides.

Response: As we indicated in the proposed rule, physicians will be able to use the "unusual circumstances" modifier when they believe that unusual circumstances justify increased payment. Of course, they will be required to justify the use of that modifier on a case-by-case basis when submitting the medical documentation necessary for the carrier to come to a decision.

[Denials of Concurrent Care Bills]

Comment: Commenters object to carrier denial of concurrent care as duplicate billing or unnecessary care because the specialty designations are so limited that it is not obvious that several different specialties are each furnishing appropriate care to the patient.

Commenters urged the expansion of concurrent care modifiers to include the designation of the specialty of the physician furnishing concurrent care services based upon an expanded and uniform list of specialties that includes all specialties.

Response: An expanded specialty list is being developed to address this concurrent care problem. The expanded list will be used under the fee schedule.

b. Multiple surgery (CPT modifier 51).

Under the proposed rule policy, if a surgeon performs more than one procedure on the same patient on the same day, we would pay 100 percent of the global fee for the highest value procedure only, 50 percent of the global fee for the second most expensive procedure, 20 percent of the global fee for the third most expensive procedure, and 10 percent of the global fee for each succeeding procedure. Procedures that are described as multiple surgery (for example, 17001 and 17002) for which we have RVUs would be paid at the value of the RVUs for that procedure code, rather than under CPT modifier 51. Some procedures in the surgery section of the CPT, specifically endoscopies and excision of skin lesions, may not readily lend themselves to the proposed

multiple surgery policy. We requested comments on these and other procedures when the multiple surgery policy would result in inequitable payment.

[Reduced Payment for Multiple Surgeries]

Comment: Most commenters supported our general concept of having reduced payment levels for multiple surgeries. Some agreed with our proposed multiple surgery policy (CPT modifier 51) of paying 100 percent of the global fee for the highest valued procedure, 50 percent of the next highest procedure, 20 percent of the next highest procedure, and 10 percent of each succeeding procedure. Others commented that the policy should be based on a study of the resources involved, not on arbitrary standard percentages across all procedures, which could result in inequitable payments. One commenter stated that there was always an intrinsic level of work inherent in each procedure and suggested that this level should never be valued at less than 50 percent of the global fee for the service. Some commenters stated that the policy should not apply to certain services such as foot surgery and some dermatological procedures because when multiple toes or skin excisions are done, the same resources are involved for each toe or excision.

Response: As we stated in the proposed rule, the Harvard study did not produce data on the resources involved in furnishing multiple surgeries. We, therefore, cannot base our standardized multiple surgical policy on a resource-based scale. However, the concept of reduced billings for multiple surgeries has been an accepted practice by physicians for many years. For example, the 1974 edition of the California Relative Value Studies (CRVS) published by the California Medical Society provided ground rules under which 100 percent of the physician's charge would be billed only for the first or major procedure; 50 percent would be billed for the second procedure, 25 percent for a third procedure, etc. Similar rules were included in earlier versions of the CRVS and the relative value scales of many other states and national specialty organizations. Upon further analysis, we agree that reductions to 20 and 10 percent of the global fee may not adequately compensate for the work involved under a resource-based system. We will, therefore, pay for multiple surgeries at 100 percent of the global fee for the highest valued procedure, at 50 percent

of the global fee for the second highest valued procedure, and at 25 percent of the global fee for each succeeding procedure. Each procedure after the fifth procedure will be paid by special report. Our medical consultants advise us that cases with more than five procedures should be extremely rare. We believe that the added documentation requirement along with physician comparative performance reports and our intra-operative computer edits will prevent abuse of the multiple surgery policy through excessive "unbundling".

For certain dermatology services, there are separate CPT codes for multiple surgical procedures (for example, CPT codes 11201, 17001, and 17002). For these procedures, the multiple procedure rules will not apply. Rather, we are presenting RVUs for these codes. For other dermatologic procedures, we believe a 50 percent reduction in the value is appropriate for the second procedure since pre- and post-work and practice expenses will be diminished. However, beyond the second procedure, since there may not be the same reductions in work effort that is associated with multiple surgery through the same incision, a physician may submit a "by report" bill when three or more lesions are removed.

[Mohs Micrographic Surgery]

Comment: Some commenters stated that Mohs micrographic surgery, CPT codes 17303 through 17310, should be exempt from the multiple surgery reductions. These are a series of surgeries which, while done on the same day, are done at different operative sessions and are clearly separate procedures in a series of procedures.

Response: We agree that these surgical procedures are contemplated to be separate staged procedures; they will be paid separately with no multiple surgery reductions.

[Multiple Surgery Policy for Multiple Trauma]

Comment: Some commenters expressed concern that the multiple surgery policy would result in inadequate payment when a number of different surgeons are operating on different body parts at the same time, such as in the case of a multiple trauma patient.

Response: These cases will not be subject to the multiple surgery policy. The multiple surgery policy will apply to multiple surgery done by the same surgeon on the same day. Each physician will be paid separately for his or her services.

c. *Bilateral surgery (CPT modifier 50).* The bilateral modifier is used to indicate

cases in which a procedure was performed on both sides of the body. The CPT identifies surgical procedures that are typically bilateral in nature. For these codes, the bilateral modifier would not result in increased payment.

In the absence of any evidence with respect to the actual difference in work for bilateral procedures, we proposed to continue the historic practice of paying 150 percent of the global fee.

[Bilateral Surgery Code Applying to Ophthalmic Procedures]

Comment: The CPT code for bilateral surgery (CPT modifier 50) should not apply to ophthalmic procedures or to the extremities (hands, feet, knees) as it requires the same amount of work for each eye, foot, etc. This policy would merely encourage physicians to bring the patient in on two separate occasions and do each eye, foot, etc., separately.

Response: Harvard did not have data on the resources involved in miscellaneous bilateral surgery and surveyed very few procedures that were bilateral. Like the multiple surgery policy, the use of a bilateral modifier and payment by carriers at 150 percent of the global fee in bilateral cases is a long accepted practice. Until resource data are available, we plan to continue the 150 percent policy. While the actual intra-operative services may be the same for each eye or extremity, we believe the pre-operative and post-operative services are reduced.

d. *Providers furnishing less than the global fee package (CPT modifiers 54, 55, and 56).* Under the current reasonable charge policy, the sum of all allowances for all practitioners who furnished parts of the services included in a global fee (and who billed using one or more of these modifiers) must not exceed the total amount of the allowance that would have been paid to a single practitioner under the global fee for the procedure. We proposed to continue to pay the same amount for surgical services when they are furnished by several physicians as we would pay if only one physician furnished all of the services in the global package. However, we proposed to pay each physician directly for the services furnished to the beneficiary based on the RVUs of the component furnished.

[Physicians Other Than Surgeons Should be Paid Without Regard to Global Fee]

Comment: Commenters objected to the policy that the sum of payments to multiple physicians furnishing services within a global package (CPT modifiers 54, 55, and 56) may not exceed the value of the global fee for the procedure. They

stated that since only the pre- and post-operative services of the surgeon were studied by Harvard in setting the global RVUs (not the services of other physicians such as cardiologists, internists, anesthesiologists, intensivists, or other physicians who may furnish this care), a physician other than the surgeon who furnish follow-up care should be paid without regard to the total global fee.

Response: We disagree. The concept of a global fee for a surgery for which the surgeon charges a single global fee and furnishes all usual and necessary services associated with a surgery and follow-up recovery is a long established concept. To ensure equitable payment under the fee schedule, it is necessary to establish a uniform national global package for each surgery. Since the surgeon usually can be expected to furnish the complete package of services, it is entirely appropriate that the value of the package be established on the basis of the value of the surgeon's services. When someone other than the surgeon furnishes services that the surgeon would normally furnish, he or she is merely substituting for the surgeon. The value of the package does not change.

However, there appears to be some misunderstanding concerning the services of other physicians—for example, a nephrologist, an infectious disease specialist for severe infection—furnishing services in addition to those normally furnished by the surgeon when a patient develops renal insufficiency. As discussed in the section of the proposed rule on global surgery, if the services of these other physicians are required in addition to the normal pre- and post-operative services of the surgeon, they will be paid outside of the global fee.

[Apportioning Payment for Post-Operative Care Furnished by Different Physicians]

Comment: A commenter suggested that, if normal post-operative care is furnished by more than one physician, the payment should not be apportioned according to the number of days in the portion of the 90-day period furnished by each physician since the number of visits and intensity of care required during different times in the period varies. The commenter stated that as an example, under the proposal in the proposed rule, a physician furnishing the first 30 days of post-operative care would receive 33 percent of the value of the care, while the physician furnishing the last 60 days of care would receive 66 percent. The commenter noted that, in

reality, the physician furnishing the first 30 days of care might have furnished 4 visits, while the physician providing the last 60 days of care might have furnished only 1 visit. The commenter suggested that a more equitable way to apportion the payment for post-operative care be developed, perhaps based on the portion of total post-operative visits.

Response: We agree that our proposed policy may provide for inequities in certain situations. We are working to develop a method that will be more equitable from a payment standpoint. However, there are severe operational problems in apportioning the payment based on the total post-operative visits furnished. Thus, at least for now, we will follow our proposed policy of apportioning payments based on the number of days in the portion of the 90-day period furnished by each physician.

[Eye Surgery Post-Operative Recovery]

Comment: Ophthalmologists commented that post-operative recovery from eye surgery is extremely variable. Many times follow-up care includes a hospitalization and a re-operation and a number of visits and diagnostic tests to evaluate the recovery. The commenters stated that this care should be paid outside of the global fee for the original surgery.

Response: We disagree. The purpose of a global fee is to pay for all usual pre-, post-, and intra-operative services of the surgeon necessary for a normal and complete recovery from the surgery. Recognizing that in some cases a re-operation is necessary, we do allow payment for the re-operation at 50 percent of the value of the intra-operative services in our global policy. No additional payment for the normal post-operative care of the surgeon is made. We emphasize that specialized diagnostic tests not normally a part of the surgical procedure and recovery will be paid outside of the global fee.

[Post-Operative Portion of the Global Fee for Cataract Surgery]

Comment: Ophthalmologists and optometrists commented that the post-operative portion of the global surgery payment for cataract removal (CPT modifier 66984) is overstated at 30 percent and that it should be about 20 percent. Similar but less procedure-specific comments were received from other specialties.

Response: We agree. Ophthalmology and optometry commenters stated that most post-operative care for 66984 required about 4 to 5 visits, which if valued and paid separately would equal about 20 percent of the global fee. We

are therefore changing the post-operative care percentage of code 66984 to 20 percent. This means that a physician billing for post-operative care only, codes 66984 and 66985 will be paid 20 percent of the global fee.

As to other commenters, we will pay each physician directly for the portion of the global surgery services furnished to the beneficiary. We believe the surgeon always furnishes the usual and necessary pre- and intra-operative services, and also, with a few exceptions, in-hospital post-operative services. In most cases, the surgeon also furnishes the post-operative office services necessary to assure normal recovery from the surgery. Recognizing that there are cases when the surgeon turns over the out-of-hospital recovery care to another physician, however, we have determined percentages for families of procedures for paying for usual out-of-hospital post-operative care if furnished by someone other than the surgeon. These are weighted percentages based on the percentage of total global surgical work representing office post-operative care from the Harvard survey.

POST-OPERATIVE PERCENT OF TOTAL RVUS BY PROCEDURE FAMILY

Family	Procedure codes	Post-operative percentage
Integumentary.....	10000-19499	21
Musculoskeletal.....	20000-29909	21
Respiratory.....	30000-32999	13
Hemic and lymphatic.....	38100-38999	16
Mediastinum.....	39000-39599	7
Digestive.....	40490-49999	12
Urinary.....	50010-53899	17
Male genital.....	54000-55980	15
Female genital.....	56000-58999	15
Maternity.....	59000-59899	22
Endocrine.....	60000-60699	9
Nervous.....	61000-64999	14
Eye.....	65091-68899	20
Auditory.....	69000-69979	8

[Care During a Global Surgical Period]

Comment: Commenters objected to the possibility of a nonphysician practitioner or non-MD or DO furnishing care during part of a global surgical period. In particular, ophthalmologists objected to paying part of the global fee to optometrists for post-cataract surgical care.

Response: We have not prohibited nonphysician practitioners or limited licensed practitioners from furnishing part of the services in a global period. Non-MD and DOs, who meet the definition of "physician" in the law, and nonphysician practitioners are restricted

only by the Act and by State and local laws regarding the services they perform.

[Require Reporting of Modifier and License Number for PTs]

Comment: Commenters requested that we require in regulations that the services furnished "incident to a physician's service" must be furnished by qualified individuals. For this reason, they supported requiring use of a modifier if a service incident to a physician's service is furnished by an individual other than a physician. In the case of physical therapy, they asked that we require the license number of the PT who performed or supervised the service to be submitted on the claim form.

Response: As we explain further in our discussion of modifiers, we have decided not to use this modifier at this time. Similarly, we are not requiring reporting of the license number of the PT who performed or supervised a service incident to a physician's service because of the burden it would impose on the physician. We are confident that physicians will use only qualified personnel to furnish these services.

e. *Physicians who assist at surgery (CPT modifiers 80, 81, and 82).* We proposed to set the payment level for assistants-at-surgery at the lower of the actual charge or 16 percent of the fee schedule amount for the global surgical service as required by law.

[Modifiers for Assistant-at-Surgery]

Comment: Commenters expressed the most interest in the modifiers for assistant-at-surgery (modifiers 80, 81, and 82). The commenters stressed that paying for assistants-at-surgery at 16 percent of the global fee was too low and would make it difficult to find physicians willing to assist. They commented that in a resource-based system payments for assistants should be based on the resources involved in each case. They also commented that the list of procedures for which no payment would be made for an assistant should be revised as it contained some procedures for which an assistant was necessary.

Response: The policy on assistants-at-surgery is not a result of fee schedule implementation or new in the proposed rule. Section 1848(i)(2) of the Act sets the payment level at 16 percent of the global fee for the surgery both under the present system, effective on January 1, 1991, and under the fee schedule, effective January 1, 1992. We have no discretion in this matter. This section of the Act also requires that we not pay for

an assistant in cases that national data show use an assistant less than 5 percent of the time. We have published this list in the Medicare Carriers Manual. After consultation with the American College of Surgeons, we recently revised and shortened the list.

f. *Two surgeons and surgical team (CPT modifiers 62 and 66).* For co-surgeons (modifier 62), we proposed to continue the current predominant carrier practice of paying 125 percent of the global fee and dividing the payment equally between the two surgeons. No payment would be made for an assistant-at-surgery in these cases.

For team surgery (modifier 66), we proposed to continue to allow our carrier medical consultants to determine the payment amounts for team surgery on an individual basis.

[Global Fee Payment Level]

Comment: Some commenters supported our proposed payment of 125 percent of the global fee for co-surgeons (modifier 62). Others supported the general concept but suggested payment of 100 percent of the global fee plus 100 percent of the intra-operative services or 150 percent of the global fee.

Response: Paying for co-surgeons at 125 percent of the global fee is by far the predominant existing practice and has long been accepted by the physician community.

g. *Unusual services (CPT modifier 22) or reduced services (CPT modifier 52).* We proposed to continue to permit carriers to increase or decrease payment for unusual circumstances, based on their review of applicable medical records or other documentation.

[Unusual Services Modifier]

Comment: A commenter stated that CPT modifier 22, unusual services, should not be eliminated and that some outlier policy is necessary for highly unusual cases.

Response: We agree but are puzzled by this comment as the proposed rule clearly states that modifier 22 will be maintained to allow carriers the discretion to increase payments in highly unusual cases.

[Carrier Authority to Downcode]

Comment: Commenters supported the use of unusual or reduced services modifiers, but they opposed giving carriers the authority to downcode, upcode, or otherwise decrease or increase payment for service based on carrier discretion. The commenters believe our national policy should govern any increase or decrease in payment as a result of the use of these modifiers.

Response: Carriers will have the authority to increase or decrease payment when the "unusual services" or "reduced services" modifiers are used.

[Different Procedures Performed on the Same Day by Several Surgeons]

Comment: Commenters believe several surgeons each performing distinctly different procedures on the same day for the same patient should each be paid the full payment for the surgery. The commenters stated that the unusual services modifier should apply in these cases.

Response: We agree that if several surgeons each perform distinctly different and unrelated procedures on the same day for the same patient, each physician should be paid the full payment for the surgery performed. There is, however, no need to use the unusual services modifier unless there is something unusual about an individual surgery. Each surgeon should bill using the appropriate code describing the surgery performed.

[Limitation of Unusual Services Modifier]

Comment: Commenters indicated that we should not use the unusual services or reduced services modifiers to exclude other more specific CPT modifiers and codes.

Response: We recognize that there may be specific modifiers that will describe some of the circumstances in which unusual payment may be warranted. However, the reason for using the "unusual" and "reduced" services modifiers is to flag special circumstances for review by report to determine if a payment adjustment is warranted in rare circumstances.

h. *Multiple modifiers (CPT modifier 99).* We believe a national policy regarding the application of multiple modifiers is necessary in order to establish nationally uniform and consistent payments. In the proposed rule, we stated that we would analyze the use of multiple modifiers and develop operational instructions to carriers on how to pay for claims with multiple modifiers.

[Limitation on the Number of Modifiers]

Comment: Commenters opposed any limit on the number of modifiers that would affect payment. They stated that payment should be adjusted no matter how many modifiers apply.

Response: We have decided that our uniform national policy will be to apply up to two modifiers, with any claims to which additional modifiers may apply priced manually by the carriers.

i. *Multiple patients and single patient modifiers on nursing home visit bills (HCPCS alpha-numeric modifiers MP and SP).* The MP and SP modifiers are currently used to identify visits to patients in nursing homes (other than patients receiving covered Part A care in NFs). Our current payment policy limits payment for routine visits to MPs in these facilities to payment that would be made for a follow-up office visit. Payment for a routine visit to an SP in one of these facilities is limited to the payment that would be made for a follow-up home visit. Payment for a visit to treat an acute condition is made at the visit level that reflects the services furnished, regardless of the number of patients seen at the facility.

We proposed to pay for all visits to patients in facilities classified by Medicare and by Medicaid as NFs without regard to the number of patients the physician sees at the facility.

[Abolition of SP and MP Nursing Home Modifiers]

Comment: Commenters supported abolishing the SP and MP nursing home modifiers.

Response: We are not using the SP and MP modifiers for nursing home visits under the fee schedule.

j. *Modifiers that would not affect payment levels.* The presence or absence of the following modifiers would not increase or decrease payment levels under the physician fee schedule, although the modifiers may continue to be used for administrative purposes, including utilization reviews.

- CPT modifiers that do not affect payment.
- HCPCS alpha-numeric modifiers that do not affect fee schedule payment amounts.
- Carrier unique local modifiers (HCPCS Level 3 modifiers beginning with the letters w through z).

We proposed to establish, for administrative purposes only, modifiers to identify monitored anesthesia care and to identify office visits furnished solely by a non-physician practitioner under the "incident to a physician's service" provision.

[Use of a Modifier for "Incident to" Services Provided by Non-Physicians]

Comment: Commenters objected to the use of an informational modifier to be reported when the physician bills for a service furnished as incident to a physician's service that was furnished by a non-physician. They believe it would ultimately be used to result in lessened payment for these services and that payment to primary care physicians

would be adversely affected. Commenters also objected to this modifier, because they stated that it would increase paperwork burden on physicians. Commenters also stated that since the modifier would not affect payment, it would not be consistently used and the data gathered from it would not be valid.

Response: We are not requiring use of this modifier at this time.

k. *Travel.* We proposed not to make separate payment for travel expenses incurred by physicians. We view these services as part of the practice expense of a medical practice; therefore, they are compensated adequately through the practice expense component of the relative value for a service.

[Travel Costs as Part of Practice Expenses]

Comment: Commenters objected to our assertion that travel costs are viewed as part of practice expenses, especially in the case of rural physicians or other physicians furnishing services in rural areas. They alleged that travel expenses, both the share of practice expenses and the fuel and automobile upkeep, are higher in rural areas and that travel costs should be paid separately until the GPCIs are revised to account for the difference. They state that the GPCIs assume that travel expenses are constant across rural and urban areas, although AMA studies have shown that many practice costs such as travel differ among rural and urban areas.

Response: It is true that, in establishing the GPCIs, we considered travel (for example, automobile expenses) as being a nationally uniform expense. We do not have data at this time to determine to what extent travel costs vary by geographic area. We will consider this issue further as part of our obligation to periodically review the GPCIs.

[Lack of Payment for Unusual Travel]

Comment: Commenters objected to the lack of payment for unusual travel, in particular for certain specialties. They indicated that pathologists, radiologists, and anesthesiologists routinely travel to rural hospitals to furnish essential care in rural hospitals that do not have these physicians available on a routine basis. They indicated that the payment for unusual travel is how these specialists are paid for the expense of travel and the "down" time during the surgeries in these settings. They indicated that, if we do not pay for unusual travel in these settings, these specialists would no longer go to rural hospitals during these surgeries, and that both rural hospitals

and their patients would be adversely affected.

Response: We acknowledge that there may be rare circumstances in which unusual travel will be appropriately paid because the distance to be traveled is unusually long (for example, over 100 miles each way) and there are no other physicians qualified to furnish the service within that distance of the hospital. Therefore, in unusual cases, physicians may bill CPT code 99082 (Unusual travel) and carriers will pay if appropriate, and review each individual case in question. Permitting payment for unusual travel on a "by report" basis under these unusual circumstances should ameliorate any problems of access to services in rural hospitals.

Comment: Commenters indicated that payment should be made for travel and other unique expenses for the physician who makes house calls. Commenters indicated that we recognize travel by nonphysician practitioners and should also recognize it for physicians.

Response: In establishing the RVUs for home visits, we attempted to recognize the higher costs associated with performing these visits. This should appropriately compensate physicians for any higher travel costs associated with home visits.

4. New Physician/Practitioner Adjustment

Under the law, we are required to reduce the fee schedule payment for physicians and independently practicing PTs and OTs who are in their first through fourth years of practice if certain conditions are met.

As specified in the statute, we will not apply the new practitioner adjustment to primary care services furnished by physicians (as defined in section 1842(i)(4) of the Act) or to services furnished by physicians or PTs or OTs in a rural area (as defined in section 1886(d)(2)(D) of the Act) that is designated, under section 332(a)(1)(A) of the Public Health Service Act, as a Health Professional Shortage Area (HPSA).

We explained in the proposed rule that the payment for the service of a new physician would be 80 percent of the fee schedule amount in the first year, 85 percent of the fee schedule amount in the second year, 90 percent of the fee schedule amount in the third year, and 95 percent of the fee schedule amount in the fourth year. These percentages are specified in statute.

We explained in the proposed rule that the "first year of practice" was defined in the statute as the first full CY during the first 6 months of which the physician or independently practicing

PT or OT furnishes professional services for which payment may be made under Part B plus any portion of the prior CY if that prior year does not meet the first 6 months' test. The second, third, and fourth years of practice would be the first, second, and third CYs respectively, following the first year of practice. These reductions would apply to each physician based on his or her status as a "new physician", regardless of whether the new physician is a member of a group practice.

[Limits on Payment for New Physicians]

Comment: Many commenters addressed the issue of the Medicare limits on payment for new physicians. Most of the commenters argued that newly trained physicians frequently possess better state of the art knowledge and techniques than established physicians and that there should be equal pay for equal work. Other commenters indicated that the costs of operating a medical practice for a new physician are just as high as for an established physician and, in fact, with the educational loans that need to be repaid, costs can be even higher. A number of commenters remarked that the limits were inconsistent with the theory behind a resource-based payment system. Several commenters indicated that the definition of the "first year of practice" is discriminatory because it penalizes not only physicians newly out of training (who do not typically start practicing until July and are consequently subject to the 80 percent limit for 18 months), but also experienced physicians who neither previously treated nor billed Medicare patients (for example, military, hospital-based, or foreign physicians). Other commenters recommended that the definition of "first year of practice" be simplified to mean the first CY ending on December 31 during which the physician furnishes professional services to Medicare beneficiaries, while others recommend that it be simplified to mean the first 12 months that a physician is in practice. They note that the definition used in the proposed rule could mean that a new physician would be considered to be in his or her first year of practice for up to 23 months.

Response: Section 4106(b) of Public Law 101-508 specifically provides for application of the limits under the fee schedule to physicians in the first through fourth years of practice. The definition of the "first year of practice" is also established by statute as the first full CY of furnishing physician services for which payment is made (either to the physician or the physician's employer)

under Medicare Part B. The commenters are correct that this could mean that a physician first beginning practice in February would be considered to be a first year physician through December of the following year, or a total of 23 months. Since the law is quite specific, we consequently have no administrative discretion in this matter. However, an amendment to this provision is contained in H.R. 1555, the Technical Corrections Acts of 1991. This bill would modify the definition of "first year of practice" to be "the end of the calendar year during the first 6 months which the physician has furnished professional services while the physician or practitioner is not in an internship or residency training program."

We believe the provision that phases in payment increases for new physicians is sound policy and is consistent with a resource-based fee schedule. First, in most professions, there is an increase in the earnings profile, with younger persons earning less than their more established counterparts. For example, a recent study for us found that most HMOs use a payment differential based on experience. Second, the RVS embodies physician work, practice expenses, and malpractice components for each service. The RVS measures the average relative resources for performing different procedures, but it does not establish payments for individual services. The new physician policy fully recognizes the resource-based RVS. However, the phasing in of payment increments effectively establishes different monetary CFs for first through fourth year physicians.

[Determination of "New" Physicians]

Comment: A commenter raised the issue that the new physician policy has resulted in his being treated as a new physician although, before starting his own practice, he had furnished services to Medicare patients for over 10 years as an HMO-employed physician.

Response: Insofar as Part B payment has been made to either the physician or the physician's employer for professional services furnished to Medicare patients, those services will be considered by the carrier in determining the physician's year of practice.

[Decreased Payments for New Physicians]

Comment: Commenters noted that because the decreased payment levels for new physicians and certain other practitioners under section 1848(a)(4) of the Act as added by Public Law 101-508 reduce Medicare spending, there must be an upward adjustment in the fee

schedule CF in order to achieve budget neutrality.

Response: The statutory limits on payments for new physicians have been taken into account in establishing the CF for this final rule.

[Uniform Charge Structure Group Practices]

Comment: A number of commenters disagree with our proposal to apply the new physician limits to physicians in uniform charge structure group practices. Previously, this policy has applied only to physicians in independent practice.

Response: The reason that the new physician limits were not previously applied to physicians who joined group practices with a uniform charge structure was due to a combination of: (1) Long standing program policy, and (2) the administrative difficulty of implementing the limits in a group practice. Since the early years of the Medicare program, customary charges of new physicians have been set at the 50th percentile of the weighted customary charge for all physicians in a locality. By enacting the new physician limit in Public Law 100-203, Congress intended to correct for those situations when the 50th percentile charge exceeds the prevailing charge as adjusted by the MEI. (The MEI, which was established subsequent to the 50th percentile policy, constrains Medicare payment to all physicians in a locality. As a result, Medicare payment to new physicians would frequently be as high as payment to established physicians. Congress believed this was an inappropriate result.) In effect, the Public Law 100-203 provision affected only those new physicians whose customary charges were based on the 50th percentile rule. However, since the early years of the program, group practices with a uniform charge structure have been permitted to submit claims under a group billing number. As a result, Medicare customary charge profiles have been developed for the entire group rather than the individual physicians who comprise the group. Additionally, until recently, there has been no systematic way for HCFA to identify individual members of the group to determine whether the new physician limits should apply. In accordance with section 1848(a)(1) of the Act, however, payment for physician services beginning January 1, 1992 will be made on the basis of a fee schedule. Consequently, the use of customary charges has been eliminated. In section 1848(a)(4) of the Act, Congress also provided that payment limits be applied to fee schedule amounts for physicians in the first

through fourth years of practice. With the combination of these changes and the mandatory identification of performing physicians on Medicare claims, carriers are now able to appropriately apply the limits to individual physicians within a group.

[Discouragement of New Doctors From Practicing in Rural Areas]

Comment: Several commenters indicated that the new physician payment limits discourage new doctors, particularly primary care physicians, from establishing their practice in rural and other undeserved areas.

Response: Section 4106 of Public Law 101-508 provides two exemptions to the limits that otherwise apply to physicians in the first through fourth years of practice and that deal, in part, with the commenters' concern. First, the fee schedule amounts for primary care services furnished by new physicians are not subject to the limits. Second, fee schedule amounts for services furnished in rural areas that are designated HPSAs by the PHS are not subject to the new physician ceiling.

[New Physician Payment Levels Compared With Those for Other Health Care Practitioners]

Comment: Several commenters expressed concern that, as a result of the 80 percent payment limit for the physician's first year of practice, a nonphysician practitioner or limited licensed physician could receive higher Medicare payments than a new physician.

Response: The commenters are correct, this result could occur under certain conditions. However, this is a direct result of the statutory regulation.

5. Health Professional Shortage Area Bonus Payment.

Under section 1833(m) of the Act, payments in addition to the amounts otherwise payable under Part B are made to physicians who furnish covered services to Medicare beneficiaries in designated HPSAs. Section 6102(d) of Public Law 101-239 amended section 1833(m) of the Act to increase the amount of this bonus payment from 5 percent to 10 percent for services furnished after December 31, 1990. In addition, the amendment broadened the applicability of the bonus to include all designated HPSAs, eliminating the restriction under prior law to Class 1 and 2 areas. These HPSAs, which are identified by the Public Health Service (PHS) under statutory guidelines, include both rural and urban areas, and bonus payments may be made in both

rural and urban areas as of January 1, 1991. Under the statutory authority cited above, the bonus will be applied to payment amounts derived from the fee schedule (or under the transition rules) beginning in 1992. The HPSA bonus is a payment made in addition to any amount payable under the fee schedule.

[Extension of HPSA Bonus to Nonphysicians]

Comment: Some writers commented that the 10 percent bonus payment for HPSAs should be extended to nonphysician practitioners. Another commenter suggested that a 10 percent premium be paid to physicians who practice in rural areas in order to help remedy the maldistribution of physicians.

Response: The Medicare statute provides only that the incentive payments be applied to physician services furnished in geographic areas designated as HPSAs under the Public Health Service Act. We have no authority to extend the payment to other areas or practitioners.

[Home Office Location]

Comment: Another writer commented that, because their home office is located in an urban area, they would not receive the 10 percent bonus payment for services performed in a rural HPSA.

Response: The key to eligibility for the bonus payment is the site of service, not the location of the practice or billing office. If physician services are furnished in a rural or urban area that is designated as an HPSA under the Public Health Service Act, those services will be eligible for the 10 percent payment.

1. Limiting Charge on Nonparticipating Physicians

Effective January 1, 1991, the limiting charge replaced the MAAC. The limiting charge continues to reflect a physician's historical actual charge until 1993. For CY 1991, the limiting charge is the same percentage (but no more than 40 percent for visits and consultation services, and 25 percent for other services) above the 1991 prevailing charge for a nonparticipating physician as the percentage by which a physician's 1990 MAAC exceeded the 1990 prevailing charge for a nonparticipating physician. For CY 1992, the limiting charge is the same percentage (but no more than 20 percent) above the 1992 fee schedule amount for nonparticipating physicians as the percentage by which the physician's 1991 limiting charge exceeded the 1991 prevailing charge for nonparticipating physicians.

Beginning January 1, 1993, the limiting charge is 115 percent of the fee schedule amount for nonparticipating physicians.

[Limiting Charge Levels Below MAAC]

Comment: Commenters stated that the limiting charge levels are far below the MAAC.

Response: The MAAC, which served as a limit on the actual charges of nonparticipating physicians before 1991, was based on an individual physician's actual charges in the April through June 1984 quarter. Since it was based on individual physician charging practices, there was substantial variation in the MAAC levels between physicians. This made it difficult to monitor and for beneficiaries to understand. In addition, in some cases the MAAC levels were two and three times the Medicare allowance so that balance billing protection was limited. To remedy these problems, Congress chose to replace the MAAC with the limiting charge system, which limits balance billing to a percentage above the prevailing charge or fee schedule amount. It is true that the limiting charge levels for many physicians (those physicians whose charge levels were far in excess of the prevailing charge or fee schedule amount) will be below the MAAC levels.

[Beneficiary's Ability to Pay]

Comment: Commenters stated that beneficiaries who can afford to pay charges higher than the limiting charge should be required, or at least allowed, to pay higher amounts.

Response: The statute does not provide for any exceptions based on a beneficiary's ability to pay. Physicians are prohibited from charging more than the limiting charge regardless of whether a beneficiary is willing or able to pay a higher amount.

[Effect of Limiting Charge on Access to Care]

Comment: Commenters believe the limiting charge would adversely affect access to care.

Response: Since the limiting charge went into effect on January 1, 1991, there has been no evidence that it has significantly affected access to care. Consistent with the law, however, we will be closely monitoring the effect of the fee schedule and the limiting charge on beneficiary access to care.

[Higher Limiting Charge for Primary Care Physicians]

Comment: Commenters stated that the limiting charge should be higher for primary care physicians to assure

adequate compensation levels for their services.

Response: Congress increased the limiting charge for evaluation and management services (visits and consultations) from 125 percent to 140 percent of the 1991 prevailing charge for nonparticipating physicians. However, under section 1848(g)(2)(A), the special treatment for primary care services terminates January 1, 1992 when the fee schedule goes into effect. Under the fee schedule, most payments for primary care services are estimated to increase. Therefore, under the fee schedule, the limiting charge differential will no longer be authorized or justified.

[Mandatory Assignment]

Comment: Some commenters indicated that the limiting charge represents mandatory assignment and requested that it be eliminated. One commenter requested an exemption from the limiting charge for groups engaging in biomedical research, medical education, and furnishing indigent care. Other commenters opposed changes in the limiting charge.

Response: Congress enacted the limiting charge as part of Public Law 101-239. Any changes in the limiting charge would require new legislation.

[Use of Out-of-State Collection Agencies to Avoid Billing Limits]

Comment: Some commenters stated that balance billing limits are not useful to beneficiaries because physicians who take assignment use collection agencies in the neighboring States to bill for the difference between their actual charges and Medicare payment.

Response: If a physician takes assignment on a Medicare claim, he or she agrees to accept the Medicare payment amount as payment in full for the service he or she furnishes to the beneficiary. The physician has the legal right to bill the beneficiary or a secondary payor only for the 20 percent Medicare coinsurance. If the physician takes assignment and bills the beneficiary or another payor for more than the 20 percent copayment, he or she has violated Federal law and should be reported to the Medicare carrier. If a physician does not take assignment on a Medicare claim, he or she cannot charge the beneficiary more than the limiting charge set by Medicare for the service. If the physician violates the limiting charge restriction, he or she is subject to sanctions.

If these commenters know about abuses in this area, we urge them to report the abuses to the appropriate

officials in the carrier or the Office of the Inspector General.

J. Comments on Regulatory Impact Analysis

[Lack of Regulatory Impact Statements for Global Surgery]

Comment: Commenters objected to the absence of regulatory impact/flexibility/recordkeeping statements for the initial global surgery notice, of which they consider the proposed rule to be an extension.

Response: We stated in the January 8, 1991 proposed notice (56 FR 703) that we are not required to publish a detailed regulatory impact analysis for the global surgery policy because the proposed notice does not meet one of the Executive Order 12291 criteria for a major rule or criteria of the Regulatory Flexibility Act. We believe the economic impact as a result of the global surgery policy will be minimal because our policy, in general, closely reflects current billing practices by surgeons. The global surgery policy has become part of both the proposed rule and this final rule for the physician fee schedule, both of which include an impact statement for all of the provisions of the fee schedule.

[Medicare Payment Would be Less Than Medicaid Payment]

Comment: Several commenters expressed concern that under the proposed rules the fully implemented payment amounts would be below Medicaid rates in many States, and in some instances would be below practice expense costs. One commenter noted that some physicians refuse to treat Medicaid patients because of the low payment rates. Thus, implementation of the proposed cuts could have the same effect with respect to Medicare.

Response: As discussed in the CF section, because of the policy changes from the proposed rule, the impact of physician fee schedule implementation on physician payments per service is very different, particularly in the later years of the transition. Although the redistributive effects remain, generally shifting payments from procedural services toward cognitive services, the dampening effect of the transition adjustment on payments across the board has been eliminated. As a result, losses are generally smaller and gains generally larger. We believe the resulting payment amounts are fair and adequate and will provide an appropriate level of compensation to physicians for the services they furnish Medicare beneficiaries. Although Medicare payment amounts might be

less than Medicaid payment amounts for some services in some localities (as is the case under the current payment system), we do not believe this represents a "problem" or a threat to beneficiary access to services. In any case, Medicare payment will still generally be higher than Medicaid levels. We will monitor the situation to ensure beneficiary access to needed care.

[Access to Specialty Care]

Comment: One commenter suggested that the drastic reductions experienced by dermatologists may have the undesirable effect of shifting service to non-Medicare patients. Another commenter noted that the national goal of reducing cancer mortality would be unattainable if inadequate payment limits access to radiation oncology services. Another reported that the reductions in payment could have serious repercussions over the long term for both the quality and availability of gastroenterological care for the Medicare beneficiary. One commenter believes medical eye care for Medicare patients would virtually cease.

Response: As explained above, revision of the transition adjustment policy from the proposed rule has changed the predicted impact of the fee schedule considerably, with almost all specialties predicted to receive higher payments than they would have under the proposed rule. In addition, modifications to RVUs for various services have been made in response to specific comments received. (See comments and responses on physician RVUs for more detail.) Therefore, we believe the dire forecasts of the commenters are not likely to occur, even with respect to the specialties experiencing the largest reductions in payments per service under the fee schedule.

[Access to Internal Medicine Care]

Comment: One commenter believes physicians practicing internal medicine would continue to take care of their Medicare patients, given their professional and personal commitments to those individuals. The inadequate payment, however, would lead to growing limitations in access to care and would have a negative impact on the future of internal medicine. Another commenter cited Medicare's historic undervaluation of evaluation and management services as contributing to a crisis that threatens the access to quality care for beneficiaries. One commenter explained that since Medicare patients rely on internists more than any other physicians, the fee

schedule would have a disproportionately greater impact on internal medicine than any other physician specialty. Because of the fee schedule's inadequate recognition of internists' evaluation and management services, access to care for millions of Medicare patients that depend on internists for their medical care would be at risk.

Response: The negative impact of the physician fee schedule on payments to internists under the proposed rule resulted from the transition adjustment policy. Final rule impact analyses show the internists gaining modestly in the near term and significantly by 1996 (5 percent increase in payments per service and a 7 percent increase in total payments). Overall Medicare payments to internists are predicted to grow at an average annual rate of 13 percent over the next 5 years, when all the factors normally a part of budget estimation are taken into account.

[Staffing Problems]

Comment: Commenters expressed concerns involving staffing problems that relate to the inability to recruit students for residency slots and to the inability to retain physicians. One commenter noted that the recruitment and retention of qualified physicians into the field of infectious diseases was very difficult because of a high burn-out rate. The commenter believes the situation will not improve unless the fee schedule addresses the underpayment for cognitive physician services. The proposed rule continues the inadequate distribution of payment and would result in more limited access to care to Medicare beneficiaries. Several commenters reported an inadequate number of applicants for residency positions. In 1991, only 78 percent of internal medicine positions were filled. The commenter asserted that it was the fourth year in a row internal medicine residency programs were unable to attract enough internists to fill the available slots. The commenter believes low Medicare fees appear to be a major cause for the declining attractiveness of internal medicine. Another commenter believes the small increase in family practice fees will not significantly improve student interest in the fields of family medicine, pediatrics, and internal medicine.

Response: The whole question of the availability of physicians and the distribution of physicians among specialties and among geographic areas goes well beyond the scope of the Medicare physician fee schedule. Many factors other than Medicare payment

levels figure into an individual's decision to pursue a medical career and a particular specialty and location. Insofar as fee schedule implementation will have an effect on these decisions, however, it should be generally a beneficial effect, since the new fee structure will be primarily based on the resources used in furnishing services and on measured differences in practice costs between different geographic areas. Since the Medicare physician fee schedule is budget neutral relative to the 1991 CPR charge-based system, the argument that the fee schedule would drive large numbers of individuals away from the practice of medicine seems implausible. This is particularly true given our budget outlay prediction that Medicare payments to physicians overall will increase at an average annual rate of 12 percent during the period 1992 through 1996. (No specialty group is predicted to receive less than a 9 percent annual increase through 1996.) As a final point, we recognize that the problem of physician shortages in rural areas and in certain inner city areas persists, and we note that the HPSA bonus payments (add-ons to Medicare payments) are designed to help recruit and retain physicians in those areas.

[Access to Appropriate Care]

Comment: Several commenters stated that the reduction in payment levels would result in deterring physicians from offering Medicare beneficiaries full access to appropriate care. Several commenters see the proposed rule generating a two-tiered system of care in which the elderly are disadvantaged. Commenters say that the fee schedule results in rationing of care, using redistribution of payments as an excuse to limit utilization of and access to care to save Federal funds. Several commenters believe physicians would not take assignment once the fee schedule takes effect. Some commenters believe physicians will leave rural areas, threatening access to care for some beneficiaries. Another commented that the fee schedule would result in increased patient queueing and long lines before elective surgery. Another commenter believes that a large number of Medicare beneficiaries will have to travel considerable distances just to find access to care.

Response: Given the figures already cited from the final rule impact analyses predicting continued robust growth in Medicare physician payments over the next 5 years, these predictions seem extremely implausible. In addition, it is worth noting that Pub. L. 101-239 requires us to monitor beneficiary access to care and provide regular

reports to Congress on any problems that may be identified as a result of the implementation of physician payment reform.

[Impact on Rural Hospitals]

Comment: Commenters argued that the rural hospital impact statement in the proposed rule reflects little understanding of the problems facing rural hospitals under the proposed fee schedule. Rural hospitals do not rely on hospital-based physicians. Instead rural hospitals rely on pathologists and other medical specialists to travel on site and furnish services. The proposed rule fails to provide appropriate payment for the technical component of pathology services. It fails to provide for detention time payments and it would eliminate payment for travel expenses.

Commenters believe the proposed rule would result in rural hospital closures.

Response: In general, we expect the fee schedule to increase Medicare physician payments in rural areas relative to urban areas including physicians' services furnished in rural hospitals. While payments in many rural areas are now relatively low due to the continuing effects of low historical charges under the CPR charge system, these differences in payment relative to urban areas will be substantially reduced under the fee schedule. Under the new schedule, the fee for each Medicare physician service will be uniform nationwide, with an adjustment for relative differences in practice costs as reflected in the GPCIs. The use of the GPCI for physician work provides a significant advantage for rural areas, because this GPCI reflects only one quarter of the actual differences in practice costs relative to the national average.

In addition, use of relative values for services based on the relative resources required to furnish the services will increase payments for visits and consultations compared to procedural services such as surgery and anesthesia. Because a larger portion of care furnished in rural areas is primary care, most rural areas stand to benefit from the higher relative payments for visits and consultations.

Although we discuss these issues extensively elsewhere, we note that payments for all services, including services in rural areas, have been significantly increased in this final rule relative to the proposed rule. Finally, we have eliminated separate payments for travel. We discuss elsewhere, however, that under very unusual circumstances requiring long distances for travel, physicians can request special carrier review by billing using code 99082.

[Cost-Shifting]

Comment: Commenters believe that the fee schedule is an attempt to limit health care options for older people in an effort to save money for the government while shifting the burden to the patient and the physician. One commenter argued that as the treatment of Medicare patients becomes less and less remunerative for physicians, practice costs will remain the same or increase. Thus, in order to remain in practice, physicians will shift costs associated with treating Medicare patients to their non-Medicare patients. This will increase the cost of private health insurance and will result in an increased number of uninsured persons.

Response: As explained above, implementation of the physician fee schedule will not "save the government money" because the fee schedule under the final rule is being implemented in a budget-neutral manner. Medicare payments to physicians are predicted to increase by an average annual rate of 12 percent over the next 5 years. Thus, the commenters' statements are not supported by our impact analyses. Whether physicians experiencing reductions in payments per service will shift costs to non-Medicare patients is not within our control, but we believe the opportunities for shifting are relatively limited. The same financial pressures that beset the Medicare trust funds are experienced by private insurers, who have stepped up efforts to conduct effective utilization review, prior approval for expensive tests, and so on. It seems more likely to us that private insurers will follow suit and develop rate structures more in line with the new physician fee schedule rather than allowing their costs to rise as a result of Medicare payment changes.

K. General or Procedural Comments

[Primary Care Still Underpaid]

Comment: Some commenters stated that under the fee schedule we proposed, primary care continues to be underpaid and that surgical services continue to be overpaid commensurate with their value.

Response: We believe the historic imbalances in payment for physician work for primary care and surgical services are substantially corrected by implementation of the RVS. However, as discussed in the section on future refinements of the RVUs, we acknowledge that some additional RVU adjustments may be necessary and that the RVUs are likely to need frequent review and adjustment because the work contained in medical and surgical

services changes as new techniques, new drugs, and advanced knowledge change the services.

However, the law requires us to create payment amounts based on both resource-based relative values for work and on charge-based values for practice expenses. Therefore, the historic charges for services are responsible for a large part of the payment for each service under the fee schedule. As discussed elsewhere, we agree that further analysis is needed before it will be possible to consider refinements to practice expense and malpractice RVUs.

[Medical Care Should be Viewed as a Public Utility]

Comment: Some commenters stated that medical care should be viewed by the Federal government as a public utility to which people are entitled and that physician services and payment for them should therefore be tightly controlled by the government.

Response: The Medicare fee schedule for physician services is not an attempt to control physician services. It is the vehicle required by the law for setting payment amounts for services furnished to individuals who are insured by the Medicare insurance program.

[Provide 120 Days for Participation Decision]

Comment: Some commenters stated that to be fair, we must give physicians at least 120 days after the participating physician letter is received to make the decision regarding whether to participate or not. They believe the decision this year will be far more difficult to make than in years past, because they will need to acquire information on the impact of the fee schedule on their practice to determine if they are able to participate in Medicare or to continue to treat Medicare beneficiaries. The commenters stated that they need at least 120 days to acquire this information and to make a rational decision.

Response: We believe physicians should be able to make their participation decision within the time frame that is being provided. Carriers will furnish all physicians with the applicable fee schedule amounts and limiting charge data to assist them in making their decision.

[Podiatric Terminology]

Comment: Commenters requested that we use the statutory language when referring to doctors that furnish podiatric services; that is, "doctors of podiatric medicine."

Response: When citing the statute in this final rule, we have used the specific

statutory language. For convenience in discussing the statutory provision, we have continued to use the term "podiatrists".

[Use of Term "Limited Licensed Practitioner"]

Comment: Commenters objected to the use of the term "limited licensed practitioners" to describe physicians other than MDs or DOs. They noted that the law considers podiatrists, optometrists, dentists, oral surgeons, and chiropractors to be physicians, within the limits specified in the law, and that they should be called "physicians."

Response: We use the term "limited licensed practitioners" to differentiate MDs and DOs from other physicians whose inclusion in the definition of "physician" is more limited by the law. We have continued to use this terminology if relevant when discussing issues in the fee schedule. When this distinction in the type of physician is not necessary to the discussion, we use the term "physician" to mean anyone as defined in section 1861(r) of the Act.

[Fee Schedule Lists Subject to Comment]

Comment: Some commenters stated that the lists of major surgical procedures, minor surgical procedures, internal claims processing lists of intra-operative services, and services subject to the site-of-service differential should be published for comment.

Response: The lists of major surgical procedures, minor surgical procedures, and services subject to the site-of-service differential can be found in Addendum B of this final rule. We will accept comments on these lists for possible future revision. There is no list of intra-operative services per se. Instead, for claims processing purposes our carriers will have in their systems for each surgical code a list of codes for which no separate payment should be made if performed coincident with a major surgery. Physicians having questions about their carrier's edits should bring them to the attention of their CMD.

[Specialty Code for Emergency Medicine]

Comment: Some commenters expressed support for our effort to establish a separate specialty code for emergency medicine.

Response: We expect emergency medicine to be established as a physician specialty for Medicare purposes beginning in early 1992.

[Delay in Implementation of Fee Schedule]

Comment: Commenters requested a delay in implementation of the fee schedule, citing the absence of RVUs for many codes, many questions about the validity of the RVUs provided by Harvard, questions about the budget-neutral computation of the CF, and concerns over the effect of standardization of carrier practices on implementation of the system.

Response: The statute specifies that the system must be implemented for services furnished after December 31, 1991, and we expect to meet that requirement. We provided opportunity for public comment on the fee schedule, with the exception of some RVUs (generally for infrequently occurring services) on which we are now accepting comments. In addition, we also invited comments on several documents before publishing the proposed rule (that is, the global fee notice and the model fee schedule) to ensure maximum public knowledge and exposure to the issues in the fee schedule. We believe that the fee schedule can be implemented timely, and we do not see a valid reason to delay it.

[Re-Issuance of Another Proposed Rule]

Comment: Commenters stated that so many issues are unresolved in the proposed rule that we should either re-issue another proposed rule with the final RVUs and take a position on all other issues or the final rule should be an interim final with opportunity for comment made available on all aspects of the rule.

Response: The purpose of a proposed rule is not to resolve issues, but to present them and to solicit public comments on them. Concerning this fee schedule, we also presented the issues in two separate notices on the model fee schedule and a global surgical package. These three **Federal Register** notices represent more opportunity for public comment than is typical for a HCFA regulation and demonstrate our dedication to fulfilling our responsibilities under the Administrative Procedures Act.

In view of this extraordinary public input on this regulation, we believe that we are justified in issuing a final rule, with comment limited only to the RVUs.

[HCFA Should Disclose Details of Meetings With Physician Organization]

Comment: Commenters believe we should be required to disclose the details of consultations with organizations representing physicians

since these groups have a bias in their discussions with us. One commenter believes that the fee schedule blatantly favors general practitioners over specialists and that the economic biases of the leadership of these physician groups must be considered in determining whether the information offered to HCFA by these groups was flawed, biased, or self-serving.

Response: As we indicated earlier, we met with every physician organization that requested a meeting. Moreover, the sole purpose of these meetings was for us to hear organization comments, and they were advised that their comments should be submitted in writing if they wanted them included in our deliberations. The comments they submitted in writing are available for public review.

With respect to the comment that the RVS is biased against procedural services and toward primary care, we do not agree that the fee schedule's increased payments for primary care services and reduced payments for many procedures is the result of bias. The increases in values for primary care services are the result of the earliest and most significant finding of the Harvard study—that primary care services have been relatively undervalued under the reasonable charge payment methodology and that many procedural services have been relatively overvalued. Congress has accepted these study findings in its overvalued procedure reductions in Public Law 101-203, Public Law 101-360, Public Law 101-239, and Public Law 101-508, and in the legislation authorizing the fee schedule. The redistribution of Medicare payment under the fee schedule results from the establishment of appropriate values for primary care services relative to procedural services.

[Inadequate Time for Review of the Proposed Rule]

Comment: Commenters stated we allowed inadequate time for review and study of the proposed rule, particularly given that the proposed rule indicated that comments that are substantiated by new data or analysis of pre-existing studies would be most persuasive. Commenters stated that the 60-day time frame was an inadequate time to develop the new data that we indicated we would find persuasive or to perform a substantial analysis of the impact of the proposed rule on physicians.

Response: We believe, given the opportunity for comment on the model fee schedule published on September 4, 1990 and the global surgical notice published on January 8, 1991, the 60-day comment period on the proposed rule

afforded the public a sufficient opportunity to comment. The upcoming fee schedule was of no surprise to physicians and physician organizations, as evidenced by the studies that were commissioned by some physician organizations months in advance of the proposed rule publication. The model fee schedule, the global surgical notice and other vehicles such as our article in JAMA in August of 1990 and Harvard's earlier article in JAMA in 1988 provided advance notice on which interested parties could base a decision to perform an independent study.

["Reprints" of Proposed Rule]

Comment: Commenters stated that our decision not to reprint copies of the proposed rule after all copies had been sold and our practice of returning unfilled orders for the proposed rule despite the notice indicating availability of the document (56 FR 25792) denied interested parties the right to comment on the proposed rule.

Response: Based on our request, the Government Printing Office (GPO) initially printed twice as many copies of the proposed rule (5,000 copies) as were printed for the model fee schedule notice, although most of the model fee schedule copies were not sold. The GPO did reprint the proposed rule a second time based on the requests it received. In fact, GPO disposed of nearly 4,400 copies after requests for copies ceased. It is possible that if the commenters did not request the "special order" of Part III of the June 5, 1991 *Federal Register*, the GPO operator may have expected the commenters were requesting the June 5, 1991 *Federal Register* in its entirety, which was sold out. We returned unfilled orders for copies of the proposed rule, because we had specified that copies of the proposed rule were available from GPO and virtually all major libraries in the country.

[Due Process Under the Fee Schedule]

Comment: Commenters objected to the absence of a discussion of issues of due process under the fee schedule. They stated that current payment rules vary widely by Medicare carrier and that massive efforts at carrier standardization will be needed to implement the fee schedule. As a part of this level of standardization, they believe that there will be numerous disputes concerning how carriers have implemented the policy and they want physicians to be able to appeal erroneous payments that result from carrier errors to an independent adjudicative body. They request that a process be modeled after the Provider

Reimbursement Review Process Board that is currently used for hospitals.

Response: The statute specifies the appeal process for both Part A and Part B of the Medicare program. The Provider Reimbursement Review Board is a part of the appeals process for providers and others receiving Medicare payments from intermediaries under the hospital PPS or on a reasonable cost-related method of payment. The statute does not provide for a similar body as part of the appeals process for claims paid by carriers using a reasonable charge or fee schedule payment method. Instead, Congress has provided for review of disputed claims by Administrative Law Judges.

The commenters have, nevertheless, raised an important issue. We anticipate that there will be disputes concerning how carriers have implemented the new fee schedule. It is important that these issues be raised not only through the appeals process but also administratively. The appeals process is far better suited to correcting errors on an individual claim than to identifying and correcting across the board errors in carrier application of HCFA policy.

Physician organizations and individual physicians who believe a carrier is acting in error should discuss the issue with the professional relations staff of the carrier or, if the issue is of a medical nature, with the CMD. If the problem is not resolved at that level, it should be raised with the Associate Regional Administrator for Medicare in the HCFA regional office responsible for supervising the carrier. If the issue remains unresolved, it should be directed to the Bureau of Program Operations in HCFA's central office. Problem resolution will be expedited if the inquirer can present examples of claims he or she believes were processed incorrectly.

[Response to Comments]

Comment: Commenters stated that our refusal to respond to comments on two prior rulemaking documents (the model fee schedule and the global fee proposal) effectively disenfranchises those who submitted comments on those *Federal Register* notices. The absence of our responses to these comments indicates that we ignored these comments.

Response: The commenters are mistaken about how we handled public comments. In the model fee schedule notice, we announced that we would not respond to comments but that we would consider all comments in developing the proposed fee schedule (56 FR 25792). We found that most of the issues raised on

the model fee schedule were raised again in response to the proposed fee schedule.

Regarding comments we received on the proposed global surgery policy, we have summarized and responded in this document, to all of the comments we received before the close of the comment period. Again, we found, for the most part, that these comments duplicated the comments we received on the proposed fee schedule.

We believe the publication of these documents and our request for comments on them demonstrate our interest in the comments of the public. Moreover, the detail in which we have addressed public comments in this final rule further demonstrates that we have carefully considered comments in developing the fee schedule that will be implemented beginning January 1, 1992.

[Consultations With Commenting Organizations]

Comment: Commenters stated that we failed to meet the statutory requirement to "consult" with organizations representing physicians (section 1848(c)(2)(B)(iii) of the Act). One physician organization making the comment indicated that since it was not privy to the benefits of any consultations we initiated, it believes that we have not met the statutory requirement. This organization objects to our lack of response to the organization's call for a public hearing.

Response: We believe we have complied with our statutory obligation to consult with physician organizations. During the comment period, we met with every physician organization that requested a meeting. In addition, before the proposed rule was published, we held an open meeting with many physician organizations to discuss the Harvard values that would be the basis for the work RVUs in the proposed rule. Moreover, in the last year, the HCFA Administrator and many other HCFA officials have spoken to physician organizations across the country and have listened carefully to their concerns. In addition, we have carefully considered the comments of all organizations and individuals who commented on the proposed rule.

We do not believe the law requires us to seek out physician organizations to discuss the fee schedule, nor does it compel us to hold hearings or to hold meetings with physician organizations in a public forum.

[Public Hearing Request]

Comment: Commenters requested that we conduct a public hearing on the issues raised in the proposed rule

because the issues have lasting significance to physicians, other providers, third party payers, and beneficiaries.

Response: We are considering whether to hold some type of public hearing on the establishment of RVUs for new services and/or the revision of RVUs for current services. However, through the publication of the global fee proposed notice, the Model Fee Schedule, and the fee schedule proposed rule, we have provided more opportunity for public comments than is typically provided for any HCFA regulation. Moreover, we met during the comment period with every physician organization or other group that requested a meeting. We believe the proposed and final Federal Register notice process we have established for acquiring comment on proposed RVU additions and future changes provides for significant public input into the creation or revision of RVUs.

[X-Ray Reading Requirements]

Comment: One commenter suggested that millions of dollars could be saved yearly by eliminating the requirement that every x-ray must be "read" by a radiologist. The commenter believed that a radiologist should only be involved when called in by an attending physician.

Response: Medicare has no general requirement that every x-ray must be read by a radiologist. We believe the commenter is referring to situations in which radiologists have arrangements with hospitals to interpret all x-rays taken in the hospital. Current Medicare policy, as set forth in section 2020G of the Medicare Carriers Manual (HCFA Pub. 14-3), indicates that the radiologist's interpretation in this situation almost always qualifies for payment as a physician's service.

[Fixed Payments Based on Diagnosis]

Comment: Several commenters suggested that one of the factors causing increased health care costs is the gross overuse of many diagnostic tests. Some suggested that unnecessary tests be eliminated by providing a fixed payment rate based on diagnosis and holding the primary care physician responsible for excess expenditures.

Response: We continue to have considerable interest in some type of more bundled and/or prospective payment system for physicians' services, but these matters are beyond the scope of this rule.

[Inclusion of Tort Reform]

Comment: Several commenters suggested that any meaningful payment

reform should include Federal tort reform.

Response: Tort reform was not included in the legislation establishing the fee schedule. These suggestions should be brought to the attention of State and national legislators.

IV. Regulatory Impact Analysis

A. Executive Order 12291 and Regulatory Flexibility Act

Executive Order 12291 (E.O. 12291) requires us to prepare and publish a regulatory impact analysis for any final rule that meets one of the E.O. 12291 criteria for a "major rule"; that is, that will likely result in—

- An annual effect on the economy of \$100 million or more;
- A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- Significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612) unless the Secretary certifies that a final rule will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, all physicians are considered to be small entities.

This final rule will implement those portions of section 6102 of Public Law 101-239 that establish: (1) A fee schedule for physicians' services; and (2) a limiting charge to constrain the amounts that non participating physicians can charge Medicare beneficiaries in excess of the allowed charge for covered services. The physician fee schedule replaces the existing customary, prevailing, and reasonable (CPR) charge payment system with new standardized payment amounts computed as the product of an RVU for the service, a GAF for the fee schedule area, and a uniform national dollar CF. The statute requires that the CF for the first year be budget-neutral, such that, had the fee schedule applied during 1991, it would result in the same level of aggregate payments as will be made under the reasonable charge system. The new limiting charge replaces the MAAC mandated by prior law with new percentage limits on the amounts that nonparticipating physicians can charge beneficiaries in

excess of the amounts allowed by Medicare.

We are preparing a regulatory impact analysis because the provisions of the statute and the final regulations are expected to have major effects on the distribution of Medicare physician payments across specialties and across geographic areas. We anticipate that virtually all of the approximately 500,000 physicians who furnish covered services to Medicare beneficiaries will be affected by these policies. There may also be significant effects on beneficiary out-of-pocket costs in some cases. In addition, we have prepared an impact analysis to reflect our final change in payment for drugs furnished "incident to" a physician's service. Under this final rule, drugs will be paid for outside the physician fee schedule; therefore changes in payment for drugs will not have to be budget-neutral.

In addition, because of the complexity of the physician fee schedule and the large number of individuals who will be affected by it, we have received many questions and comments. As summarized in section III above, we received many thousands of comments on a wide range of issues in the proposed rule, including the calculation of the budget-neutral CF, the methodology for calculating the GPCI values, the refinements to the relative values for various services from the original Harvard work to the later versions, the establishment of an AHPB for purposes of the transition, and the revised visit codes and descriptors. In addition, many comments were received concerning the possible impact of the physician fee schedule. The following discussion describes what we know about the impact of the statute and the final rule on affected entities and is intended to fulfill the requirements of both E.O. 12291 and the RFA.

1. Effects on Physician Payments

a. Impact estimation methodology. Physician fee schedule impacts were estimated by comparing predicted physician payments under a continuation of the current CPR charge payment system to estimated payments under the physician fee schedule, including the transition rules in effect during 1992 through 1995. As explained in detail in the section of this preamble that discusses data file development, projections of future payments were developed by aging or updating 1989 Medicare claims data from BMAD to reflect various statutory changes and other changes. Details on the process of data source selection, data validation, and data aging are also provided in that section. Throughout the proposed impact

analyses, an assumption was made that those physicians who are predicted to receive net increases in Medicare payments and who have previously been charging less than the prevailing charge will increase their submitted charges by 50 percent of the difference between their submitted charges and the new fee schedule amounts in 1992. By 1996, we assume that these physicians will have increased all charges so as to close 90 percent of the gap between their submitted charges and the new fee schedule amount.

b. Overall fee schedule impact. Throughout the discussion below regarding the impacts of fee schedule implementation, it is important to bear in mind that payment amounts for all services will be strongly affected by two major factors. First, the transition to the fee schedule, as specified by statute, will be asymmetric in that, in 1992, payments for relatively undervalued services will increase to a greater extent than payments for overvalued services will decrease. This asymmetry results primarily from the fact that the first year change in payment is limited to 15 percent of the full fee schedule amount for the service. Because payment increases and reductions are both limited to 15 percent of the fee schedule amount, services experiencing increases move a larger fraction of the way to the full fee schedule than services experiencing decreases. Thus, our analysis indicates that total payments for relatively undervalued procedures increase faster than total payments for overvalued procedures decrease. In other words, the transition has a net cost.

Because of this systematic asymmetry that is built into the statutory transition rules, we must reduce payments in order to re-establish budget neutrality. As explained in the section of this preamble discussing the transition, we will make this adjustment for the transition costs by reducing AHPBs by 5.5 percent. This approach produces payments that are budget neutral not only in 1992, as explicitly required by statute, but throughout the transition period. This revised approach to a transition adjustment generally produces larger gains and smaller losses relative to the impact estimates associated with the proposed rule policy. The difference is particularly striking in 1996, since the effect of the "leveraged" CF reduction from the proposed rule has been eliminated. (Leveraging resulted from using the CF as the sole vehicle for making adjustments to achieve budget neutrality.)

Second, in establishing the CF, which is statutorily required to be budget neutral relative to 1991 spending levels, we will apply a volume and intensity response adjustment in anticipation of physician and beneficiary responses to changes in payment levels and policy standardization. As explained in the section of this preamble discussing the CF, we assumed that responses per physician practice will be sufficient to recoup 50 percent of the net loss of Medicare payments that "losing" physicians will otherwise experience. No volume response by "winning" physicians will be assumed. The CF has been adjusted downward by 6.5 percent to reflect these assumptions.

Finally, recent payment reductions required by Public Law 101-239 and Public Law 101-508 have affected payment levels for all physicians because the total outlay amount upon which the budget-neutral CF has been computed is less than it would have otherwise been.

In the discussion below of differential impacts by category (by specialty and by State), the effect of fee schedule implementation on any individual practitioner will depend not only on his or her specialty and locality, but on his or her own historical charging patterns and mix of services furnished. For example, even though family practitioners overall (or in a given locality) are expected to experience increases in total Medicare payment, an individual family practitioner whose historical charges were unusually high or who performed more procedural services than is typical could experience a small increase or even a decrease in Medicare payment.

In the tables included at the end of this section (displaying fee schedule impact by specialty and State), the estimates for Year 1 (1992) take into account the transition rules, under which payments for some services in some localities will reflect a blending of old and new payment amounts. In Year 5 (1996), the fee schedule is fully effective. The columns marked "Change in Payments per Service" assume no change in service frequencies; these are the changes that result simply from the new fee schedule payment rates as compared with payments under the current CPR charge payment system. The columns marked "Change in Payments" take into account not only the rate change per service but also anticipated changes in the volume and intensity of services in response to the fee changes.

The columns under the heading "Percent Increase in Total Budget

Outlays under Fee Schedule" do not compare fee schedule payments to hypothetical payments under a continuation of CPR charge payment; these percentages measure year-to-year changes in budget outlays for physician payments made under the fee schedule. These estimates reflect not only the responses to the fee and other changes, but also all the other anticipated payment updates, changes in volume, mix of services, and enrollment that are traditionally part of budget estimation for Medicare.

c. Specialty level effects. Table 1 of this section shows the estimated percentage change in Medicare physician payment from the old to the new payment system by specialty and projected total budget outlays under the fee schedule by specialty. In general, those specialties that account for more visits and fewer procedures are expected to experience larger total increases in Medicare payments than procedurally oriented specialties, including surgical specialties.

Thus, the estimates show for example, that total Medicare payments to family practitioners will increase nationally at an annual rate of about 18 percent from 1991 to 1996, whereas the total increases in Medicare payments to physicians specializing in anesthesiology and thoracic surgery will increase at a lower annual rate of about 8 percent. These figures can be compared against a national average rate of increase of 12 percent.

Comparing the fee schedule payments against a hypothetical continuation of CPR rules, Table 1 also shows that on a per service basis, payment levels in 1996 (under the fully phased-in fee schedule) will decrease by about 6 percent across all specialties (3 percent during the first year) relative to the CPR system. Again, results vary significantly by specialty. The specialties predicted to receive the largest increases in total Medicare payments relative to CPR charge payments are general and family practice, with 27 and 28 percent increases, respectively, in payments per service under the fully phased in fee schedule. Payments for these two specialties will be 29 and 30 percent higher than under the CPR payment system in 1996. Anesthesiologists and thoracic surgeons are expected to receive the largest decreases in total Medicare payments relative to a continuation of the current system. Both anesthesiologists and thoracic surgeons can expect about a 27 percent reduction in payments per service and about a 14 percent reduction in payments, as compared against a continuation of CPR

rules, when the fee schedule is fully effective. (However, as noted above, their increases in total Medicare income—including expected growth in volume and intensity, enrollment increases, and annual payment updates—are expected to be about 8 percent per year so that even "losing" specialties are expected to have higher Medicare income than they currently receive.) Differences from the CPR payment system are much smaller in the first transition year; we estimate an 11 percent reduction for anesthesiologists in payments per service and a 14 percent reduction in payments per service relative to a continuation of the CPR system for thoracic surgeons.

We have explained that Medicare-covered services furnished by limited licensed practitioners who are not MDs or DOs but who are defined as "physicians" in Medicare law are included within the scope of the fee schedule. While the statute is clear on this point, the Secretary was left with some discretion to determine precisely how these services will be coded and thus how payment amounts will be calculated. As described earlier, we will pay these limited licensed practitioners the same as MDs and DOs for services billed under the same CPT code. For those services unique to limited licensed practitioners, we developed relative values based on charge data and on consultations with CMDs.

Included on Table 1 are the effects of the change to fee schedule payment on physicians for three of the limited licensed practitioner specialties—chiropractors, optometrists, and podiatrists. Like all other physician specialties, the limited licensed practitioners are expected to receive increasing payments from Medicare from 1991 through 1996, with all three groups predicted to experience rates of increase above the national cumulative 5-year increase of 74 percent. Relative to CPR payments, payments to optometrists and podiatrists are predicted to be higher under the fee schedule, as they begin to receive payments in all cases on a par with MDs and DOs if they perform the same service. Chiropractors, whose one Medicare-covered service is performed only by them, will receive fee schedule payments based on relative values we established for that service based on consultation with CMDs. As a result, chiropractors as a group can expect higher payments than under a continuation of the CPR rules. All specialty groups other than podiatry can expect more favorable outcomes under this final rule than under the proposed

rule (and the increases for podiatry are only slightly less than under the proposed rule).

The general pattern of interspecialty redistribution is similar to that in previous simulations—those published as part of the early Harvard work, in HCFA's 1989 report to Congress ("Relative Value Scale (RVS) for Physician Services"), in the August 8, 1990 article in the *Journal of the American Medical Association* by various HCFA analysts, and in the proposed rule. As was noted in the proposed rule, when total payments are considered, the spread between specialties is reduced (effects of the fee schedule on "losing" specialties are mitigated). In all these studies, use of a payment system based on the relative value of these services as a substitute for the present reasonable charge system has consistently increased payment for visit and consultation services relative to procedural services, including surgery. Our impact analysis by specialty supports this generalization and is therefore consistent with the earlier studies, although the statutory formulas and policies set forth here differ in some ways from the assumptions used in those earlier efforts, including the proposed rule.

Also, in the past, our impact analyses generally did not incorporate volume and intensity response assumptions. Use of these assumptions does change the pattern of interspecialty redistribution somewhat, by moderating the effects of the fee schedule on "losing" specialties.

d. State level effects. Table 2 illustrates the effects of fee schedule implementation on Medicare payments by State, making clear that the fee schedule will redistribute payments not only across specialties, but across geographic areas as well. Geographic redistribution will occur for a number of reasons. First, the fee schedule will replace the current CPR charge-based payment system in which payments vary greatly and somewhat arbitrarily among States and localities (because it is based on historical charging patterns), with more standardized payment rates that vary geographically based on actual data pertaining to geographic variations in costs. Second, physician specialties that experience increases and decreases in payment per service under the fee schedule will be concentrated in different geographic areas. (For example, there are more surgeons in urban areas than in rural areas.) Third, the mix of procedures performed varies geographically even within specialties. (General practitioners do more

procedural services in rural areas than in urban areas.)

The estimates in Table 2 show that total Medicare payments to physicians nationally are expected to increase at an average annualized rate of 12 percent from 1991 to 1996, with modestly higher increases in some States and modestly lower increases in others. Predicted rates of increase vary from 10 percent in Nevada to 15 percent in Mississippi. Total cumulative increases in Medicare spending for physicians' services from 1991 to 1996 are predicted to range from 64 percent in Nevada to 99 percent in Mississippi. (Nationwide the cumulative increase is expected to be 74 percent.) As explained earlier, these budget outlay estimates take into account not only changes in payments per service and volume/billing changes resulting from fee schedule implementation, but also the annual updates, historical volume and intensity trends, enrollment growth, and other factors used by the actuaries in Medicare budget estimation.

Table 2 also allows comparison of fee schedule payments by State against payments that would result under a hypothetical continuation of the CPR charge rules through 1996. First year payments per procedure will be slightly higher than CPR payments in several States; Colorado payments are expected to exceed CPR payments by the largest margin. Relative to continuation of the CPR charge payment system, payments per service will rise by 2 percent and payments overall by 4 percent. When the fee schedule is fully effective, Mississippi is predicted to be the State experiencing the largest increases in payments overall as a result of the fee schedule. In that State, payments per service will be 12 percent higher than they would have been under a continuation of the CPR payment rules and payments overall will be 14 percent higher. Among States experiencing the largest reductions relative to the CPR system will be Alaska and Nevada. In the first transition year, physicians in Alaska can expect a 10 percent reduction in payments per service and a 2 percent reduction in payments overall. When the fee schedule is fully effective in 1996, physicians in Nevada can expect a 20 percent reduction in payments per service and a 6 percent reduction in payments overall, relative to a continuation of CPR payments. Like specialty level effects, these State level effects are generally consistent with those shown in earlier analyses.

There will also be redistributions of payments within States. Changes in payment levels could vary more widely if we compared smaller geographic

areas than States, such as fee schedule areas. Variation at the fee schedule area level could be greater than at the State level, since the effects within States tend to offset one another. (For example, many States contain both urban and rural areas. Increases in rural areas may be offset by decreases in urban areas.)

e. Effects of separate payment for drugs. We have estimated the budgetary effects of our final policy for separate payment for certain drugs. As explained in the preamble section on drug payment rules, carriers generally base payment for covered drugs on the physician's estimated cost of the drug using one of the wholesale price guides such as the Red Book, which is an annual pharmacists' reference published by the Medical Economics Company, Inc., Oradell, New Jersey. Under our final policy, carriers will be instructed to base payment for drugs on the lower of the estimated acquisition cost or the national average wholesale price of the drug as published in the Red Book and similar price listings. Our policy will therefore reduce payments for drugs by approximately \$5 million in FY 1992, \$15 million in FY 1993, \$15 million in FY 1994, \$20 million in FY 1995, and \$20 million in FY 1996.

2. Effects on Beneficiaries' Costs and Access to Services

Medicare beneficiaries incur out-of-pocket expenses in relation to their Medicare-covered services arising from (1) the monthly Part B premium (\$31.80 in 1992, up from \$29.90 in 1991), (2) the annual deductible (increased from \$75 in 1990 to \$100 in 1991), (3) the 20 percent coinsurance, and (4) balance billing (that is, billing the beneficiary for an amount in excess of the Medicare allowed charge if the claim is not assigned). The implementation of the Medicare physician fee schedule and the limiting charge on balance billing as required by law and set forth in this final rule will have important effects on the amounts of beneficiary coinsurance and the amounts of balance billing permitted.

Concern about rising beneficiary out-of-pocket costs has led to an increasing emphasis over the past several years in encouraging physicians' Medicare participation (which requires accepting assignment for all cases), in increasing assignment rates, and limiting the amounts of balance billing. In fact, since Public Law 98-369 (the Deficit Reduction Act of 1984) established the participating physician program with its differential payment rates for participating and nonparticipating physicians, enrollment in the Medicare participating physician program has

increased to 44.1 percent (April 1990 figure). Creation of the MAAC limits on balance billing (enacted as part of Public Law 99-509) gave physicians an additional incentive to participate. Participating physician charges represented approximately 72 percent of Medicare physician covered charges from April through June 1991. At the same time, assignment rates have also increased steadily so that from April through June 1991, the assignment rate based on total charges (physician and suppliers) had increased to 87 percent. With this increase in assigned claims and the MAAC limits that took effect in 1987, balance billing decreased from its CY 1986 high of \$2.9 billion to a CY 1990 total of \$2.2 billion, unadjusted for inflation or enrollment growth during this period.

Offsetting these declines in balance billing have been the recent increase in the deductible already mentioned, and continuing annual increases in the premium rate and increases in the amounts of coinsurance as the charges per service and volume and intensity of services have grown. Beneficiaries' aggregate coinsurance liabilities have increased at the same rate as Part B benefit expenditures, about 15 percent annually. (The coinsurance rate has remained constant at 20 percent.)

The net effect of all these factors on beneficiary out-of-pocket costs has been as follows. Medicare has paid an increasing fraction of the total physician bill (up from 53 percent in 1977 to 61 percent in 1987). However, because total physician expenditures have risen significantly, beneficiaries have had significant increases in out-of-pocket costs (even though they represent a smaller fraction of total costs). These out-of-pocket costs include premiums paid to both Medicare and supplemental (Medigap) insurers as well as amounts paid directly to physicians.

Under the fee schedule, some beneficiaries will pay more coinsurance, while others will pay less, depending on the effects of the fee schedule in their fee schedule area and the mix of services they receive. Typically, coinsurance for visits and consultations will increase, while coinsurance for surgical and imaging services will decrease. On the other hand, virtually all beneficiaries who receive services from nonparticipating physicians will benefit from the more stringent balance billing limits. And, the numbers of participating physicians and assigned claims will likely increase as more physicians find the higher payment rates available to participating physicians

outweighing the possibility for income enhancement through balance billing.

A simulation done with 1987 data in conjunction with the October 1989 Report to Congress: Medicare Physician Payment, under assumptions similar although not identical to those later enacted into law, showed that while the percentage of beneficiaries who have coinsurance liability from 0 to \$100 would decrease slightly and the percentage with liability from \$101 to \$250 would increase slightly, there would be no appreciable change in the percentage with liability of \$500 or more. A more recent HCFA simulation that applied a 115 percent balance billing limit to 1988 claims data (without fee schedule effects) predicted that total balance billing would be reduced by approximately 66 percent, more than offsetting the slight increases in coinsurance for the typical beneficiary. Balance billing of more than \$1,000 per year would be almost eliminated and 90 percent of beneficiaries who pay balance bills would pay less than \$100 (as opposed to an actual figure of 74 percent before implementing the limiting charge). Based on the Report to Congress simulation, beneficiary cost sharing would be sharply decreased by the effects of the fee schedule and the billing limit changes. (This simulation assumed the old law deductible of \$75 and a 120 percent balance billing limit.) The percent of beneficiaries with total liability of over \$1,000 for physician services would be reduced from approximately 5 percent to approximately 1 percent and there would also be decreases in the percentages with liability in the \$250 to \$500 range and in the \$501 to \$1,000 range. None of these simulations estimated the likely increase in assignment rates under the new billing limits, which would make the amounts of balance billing even smaller.

In a Summer 1990 article in *Inquiry*, Janet B. Mitchell and Terri Menke analyzed possible effects of the physician fee schedule and balance billing limit on beneficiary out-of-pocket costs, using their own simulation model (derived in part from work done by the PPRC staff). Using somewhat different assumptions from the HCFA models and a 1986 data base, they reached conclusions similar to those listed above—the slight increases in coinsurance were more than offset by large decreases in balance billing for most beneficiaries. In addition, they did some analysis of the effects by beneficiary subgroup. Two points seem noteworthy. First, they observed that since primary care (usually physician

visits) makes up a large proportion of Medicare billings in rural areas, coinsurance increases for visits under the fee schedule could hit harder in some rural areas (where historical charges were lower than the new fee schedule amounts). However, balance billing is also more prevalent in rural areas and thus rural beneficiaries could benefit disproportionately from the new balance billing limit.

A second insight provided by Mitchell and Menke is that the balance billing limits, which assist beneficiaries in all demographic subgroups, constitute important protection from high cost patients. Their simulations show that patients with multiple hospital admissions may experience decreases in out-of-pocket costs averaging about 30 percent, reducing their costs by \$700 to \$800. This point is supported by our simulation data cited above, which showed sharp decreases in the numbers of beneficiaries with balance billing liability of \$1,000 or more under a 115 percent limit.

Finally, some have hypothesized that beneficiaries will further benefit from implementation of the fee schedule because it may equalize incentives to physicians across procedures. On the basis of revenues, physicians should be more financially neutral in choosing procedures. This could result in more appropriate care being furnished to Medicare beneficiaries.

3. Effects on Carriers

The major costs and workloads associated with the transition to the physician fee schedule and balance billing limits are incurred in the first 2 years for systems' changes and the need for increased capacity to train providers and respond to beneficiary inquiries. Ongoing carrier costs associated with maintenance of the fee schedule and balance billing limits are expected to be minimal.

In FY 1991, carriers spent approximately \$32.6 million on activities related to implementation of these two physician payment provisions. Limiting charge instructions were implemented in January 1991. Carriers were allocated \$1.85 million for responding to beneficiary inquiries related to balance billing. In addition, approximately \$9.1 million was required for professional relations (carrier communication with physicians and physician organizations). The major portion of additional funds needed by carriers to implement the physician fee schedule was approximately \$21.7 million, spent on standardizing coding conventions, developing new claims processing software, calculating historical payment

amounts for the transition, standardizing the global surgical definition, and other standardization requirements.

In FY 1992, funds will also be needed to complete the standardization of coding conventions, the global surgical package, and other claims processing changes. In addition, when the fee schedule becomes effective on January 1, 1992, there will be costs associated with additional pre-payment and post-payment monitoring. These costs are expected to total \$16 million in FY 1992. Responding to beneficiary inquiries will cost an estimated \$3.7 million and professional relations an estimated \$10 million. Thus, FY 1992 carrier costs for implementation of the two provisions will be \$29.7 million.

Finally, during FY 1993 through FY 1996 there will be some small continuing costs for the carriers. Programming changes to accommodate the annual fee schedule update will cost an estimated \$0.1 million per year. Monitoring of standardized payment policies and balanced billing will cost \$5.7 million per year. Total costs per year associated with the fee schedule and balance billing limit during this period will be \$5.8 million.

B. Rural Hospital Impact Statement

Section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis if a final rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

This final rule, which implements the fee schedule for physician payment and the limiting charge, will have little direct effect on payments to rural hospitals, since this rule will change only payments made to physicians and certain other practitioners under Part B of the Medicare program and will make no change in payments to hospitals under Part A. However, widespread changes in physician payments with differential effects by geographic area and specialty could have an indirect effect (both positive and negative) on some rural hospitals. In particular, the limits on outpatient department radiology and diagnostic services could be affected. Because of the interaction of the effects of the RVUs, the GAF, and the elimination of specialty differentials, it is virtually impossible to generalize about the impact of the fee schedule on rural hospitals. Payment differentials

between urban and rural physicians, however, will be much narrower than under the current CPR charge payment system and will exist only to the extent justified by the cost of the practice index. This should make it less likely that physicians will leave rural areas to relocate to urban areas solely to receive

higher fees for procedures from Medicare. Moreover, the newly increased HPSA bonus payments will also provide an incentive for physicians to continue practicing in many rural areas.

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TABLE 1--Physician Fee Schedule Impact by Specialty

Specialty	Percent Change in Allowed Charges for Fee Schedule Relative to CPR				Percent Increase in Total Budget Outlays Under Fee Schedule**	
	Year 1 (1992) change in:		Year 5 (1996) change in:		Avg. Annualized 1991-1996	Cumulative 1991-1996
	Payments Per Service	Payments*	Payments Per Service	Payments*		
All physician specialties	-3%	0%	-6%	0%	12%	74%
Family Practice	15	16	28	30	18	125
General Practice	17	18	27	29	17	124
Cardiology	-9	-3	-17	-8	10	59
Dermatology	-1	0	0	2	12	77
Internal medicine	0	1	5	7	13	85
Gastroenterology	-10	-4	-18	-9	10	58
Nephrology	-6	-2	-9	-5	11	66
Neurology	-4	-2	-4	-2	11	71
Psychiatry	-2	-1	3	5	13	82
Pulmonary	-3	-1	-2	0	12	74
Urology	-6	-2	-8	-4	11	67
Radiology	-10	-4	-22	-11	9	55
Anesthesiology	-11	-4	-27	-14	8	50
Pathology	-10	-4	-20	-10	9	57
General Surgery	-8	-3	-13	-7	10	62
Neurosurgery	-10	-4	-18	-9	10	58
Ophthalmology	-11	-4	-21	-11	9	55
Orthopedic Surgery	-8	-3	-11	-5	10	64
Otolaryngology	2	3	3	5	13	83
Plastic Surgery	-8	-3	-13	-6	10	63
Thoracic Surgery	-14	-5	-27	-14	8	50
Clinics	-1	0	-1	1	12	75
Optometry	20	21	41	43	20	148
Chiropractic	12	13	26	28	17	122
Podiatry	6	7	14	16	15	102

* Includes changes in payments per service as well as anticipated volume/intensity responses. See text.

** Incorporates changes in payment per service and anticipated volume/intensity responses to payment changes for that specialty.

In addition, for each specialty, we have assumed the same volume/intensity baseline, growth in patient population, and payment updates.

Note: Assumes some physicians will submit charges below the fee schedule amounts. (see text)

TABLE 2--Physician Fee Schedule Impact by State

State	Percent Change in Allowed Charges for Fee Schedule Relative to CPR				Percent Increase in Total Budget Outlays Under Fee Schedule**	
	Year 1 (1992) change in:		Year 5 (1996) change in:		Avg. Annualized 1991-1996	Cumulative 1991-1996
	Payments Per Service	Payments*	Payments Per Service	Payments*		
All States	-3%	0%	-6%	0%	12%	74%
Alabama	-4	-1	-6	-2	11	72
Alaska	-10	-2	-19	-6	11	65
Arizona	-6	-1	-13	-4	11	68
Arkansas	-4	-1	-7	-2	11	71
California	-5	-1	-14	-4	11	68
Colorado	2	4	9	11	14	94
Connecticut	-4	-1	-8	-2	11	71
Delaware	-2	0	-4	-1	12	73
District of Columbia	-3	-1	-7	-2	11	71
Florida	-8	-2	-17	-5	11	66
Georgia	-3	-1	-6	-2	11	72
Hawaii	-8	-2	-16	-5	11	67
Idaho	0	2	6	8	13	88
Illinois	-3	-1	-5	-1	12	73
Indiana	-2	0	-2	0	12	76
Iowa	0	2	9	11	14	94
Kansas	-3	-1	-4	-1	12	73
Kentucky	-1	1	0	2	12	78
Louisiana	-4	-1	-7	-2	11	71
Maine	-1	1	1	3	12	80
Maryland	-4	-1	-10	-3	11	70
Massachusetts	-4	-1	-3	-1	12	73
Michigan	0	2	4	6	13	85
Minnesota	0	2	7	9	14	91
Mississippi	1	3	12	14	15	99
Missouri	-1	1	1	3	12	80
Montana	-2	0	-2	0	12	75
Nebraska	-1	1	1	3	12	80
Nevada	-9	-2	-20	-6	10	64
New Hampshire	-1	1	6	8	14	88
New Jersey	-2	0	-4	-1	12	73
New Mexico	-3	-1	-9	-3	11	70
New York	-4	-1	-8	-2	11	71
North Carolina	-3	-1	-2	0	12	74
North Dakota	-4	-1	-5	-2	11	72
Ohio	-3	-1	-7	-2	11	72
Oklahoma	-2	0	-3	-1	12	74
Oregon	-2	0	-2	0	12	75

TABLE 2--Physician Fee Schedule Impact by State

State	Percent Change in Allowed Charges for Fee Schedule Relative to CPR			Percent Increase in Total Budget Outlays Under Fee Schedule**		
	Year 1 (1992) change in:		Year 5 (1996) change in:	Avg. Annualized		Cumulative
	Payments Per Service	Payments*		1991-1996	1991-1996	
Pennsylvania	-2	0	-4	12	73	
Rhode Island	0	2	1	12	80	
South Carolina	-2	0	4	13	85	
South Dakota	-2	0	0	12	79	
Tennessee	-3	-1	-2	12	75	
Texas	-4	-1	-11	11	69	
Utah	-1	1	5	13	87	
Vermont	-1	1	2	13	81	
Virginia	-1	1	4	13	85	
Washington	-1	1	-1	12	76	
West Virginia	-3	-1	-7	11	71	
Wisconsin	-2	0	-1	12	77	
Wyoming	1	3	8	14	92	

* Includes changes in payments per service as well as anticipated volume/intensity responses. See text.

** Incorporates changes in payment per service and anticipated volume/intensity responses to payment changes for that state. In addition, for each state, we have assumed the same volume/intensity baseline, growth in patient population, and payment updates.

Note: Assumes some physicians will submit charges below the fee schedule amounts. (see text)

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V. Information Collection Requirements

This final rule contains no information collection requirements. Consequently, this rule need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 et seq.).

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health maintenance organizations (HMO), Health professions, Kidney diseases, Laboratories, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 415

Administrative practice and procedure, Health facilities, Health professions, Medicare, Physicians, Reporting and recordkeeping requirements.

42 CFR chapter IV is amended as set forth below:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

A. Part 405 is amended as set forth below:

Subpart E—Criteria for Determination of Reasonable Charges; Reimbursement for Services of Hospital Interns, Residents, and Supervising Physicians

1. The authority citation for subpart E is revised to read as follows:

Authority: Secs. 1102, 1814(b), 1832, 1833(a), 1834(b), 1842 (b) and (h), 1848, 1861 (b) and (v), 1862(a)(14), 1866(a), 1871, 1881, 1886, 1887, and 1889 of the Social Security Act as amended (42 U.S.C. 1302, 1395f(b), 1395k, 1395l(a), 1395m(b), 1395u (b) and (h), 1395w-4, 1395x(b) and (v), 1395y(a)(14), 1395cc(a), 1395hh, 1395rr, 1395ww, 1395xx, and 1395zz).

2. In § 405.502, paragraph (f)(1) is revised to read as follows:

§ 405.502 Criteria for determining reasonable charges.

(f) *Determining payments for certain physician services furnished in outpatient hospital settings*—(1) *General rule.* If physician services of the type routinely furnished in physicians' offices are furnished in outpatient hospital settings before January 1, 1992, carriers

determine the reasonable charge for those services by applying the limits described in paragraph (f)(5) of this section.

3. In § 405.509, a new paragraph (c) is added to read as follows:

§ 405.509 Determining the inflation-indexed charge.

(c) The inflation-indexed charge does not apply to any services, supplies, or equipment furnished after December 31, 1991, that are covered under or limited by the fee schedule for physicians' services established under section 1848 of the Act and part 415 of this chapter. These services are subject to the Medicare Economic Index described in § 415.30 of this chapter.

4. Section 405.517 is added to read as follows:

§ 405.517 Payment for drugs that are not paid on a cost or prospective payment basis.

(a) *Applicability.* Payment for a drug that is not paid on a cost or prospective payment basis is determined by the standard methodology described in paragraph (b) of this section. Examples of when this procedure applies includes a drug furnished incident to a physician's service and a drug furnished by an independent dialysis facility that is not included in the ESRD composite rate set forth in § 413.170(c) of this chapter.

(b) *Methodology.* Payment for a drug described in paragraph (a) of this section is based on the lower of the estimated acquisition cost or the national average wholesale price of the drug. The estimated acquisition cost is determined based on surveys of the actual invoice prices paid for the drug. In calculating the estimated acquisition cost of a drug, the carrier may consider factors such as inventory, waste, and spoilage.

(c) *Multiple-Source drugs.* For multiple-source drugs, payment is based on the lower of the estimated acquisition cost described in paragraph (b) of this section or the wholesale price that, for this purpose, is defined as the median price for all sources of the generic form of the drug.

5. Sections 405.521 through 405.524 are revised to read as follows:

§ 405.521 Services of attending physicians supervising interns and residents.

(a) *Basic rules.* (1) Attending physicians' services furnished to beneficiaries in a teaching setting are covered under Medicare Part B; and

(2) The payment for these services is on the same fee schedule basis as other

physician services except in those hospitals that have elected cost reimbursement under paragraph (d)(2) of this section.

(b) *Physician direction requirements.*

(1) Payment on the basis of the physician fee schedule applies to the professional services furnished to a beneficiary by the attending physician when the attending physician furnishes personal and identifiable direction to interns or residents who are participating in the care of the patient.

(2) In the case of major surgical procedures and other complex and dangerous procedures or situations, the attending physician must personally supervise the residents and interns whom the physician involves in the care of the patients.

(3) Part B payment may be made for the services of an attending physician who involves residents and interns in the care of a patient only if the physician assumes and fulfills the same responsibilities for this patient as for other paying patients.

(4) The carrying out by the physician of these responsibilities is demonstrated by actions such as: Reviewing the patient's history and physical examination and personally examining the patient within a reasonable period after admission; confirming or revising diagnosis; determining the course of treatment to be followed; ensuring that any supervision needed by the interns and residents is furnished; and making frequent reviews of the patient's progress.

(c) *Billing procedures.* (1) Charges for the services of the attending physician may be billed either directly by the physician or by the hospital under arrangements between the physician and the hospital.

(2) In either case, the amount payable is determined using the same criteria that are used in applying the physician fee schedule to services that the physician furnishes to other patients. (The physician fee schedule rules are set forth in part 415 of this chapter.)

(d) *Payment to the hospital.* (1) For services to a patient that involve the participation of residents or interns, the hospital can receive payment for an appropriate share of the compensation it pays its residents and interns as described in § 413.86 of this chapter.

(2) A hospital with an approved teaching program may elect to receive payment on a reasonable cost basis for the direct medical and surgical services of its physicians in lieu of any payment on a reasonable charge or fee schedule basis that might otherwise be payable for these services.

(3) A hospital may elect to receive cost reimbursement only if—

(i) All physicians who furnish Medicare-covered services in the hospital agree not to bill charges for these services; or

(ii) All the physicians are employees of the hospital and as a condition of employment are precluded from billing for these services.

(4) If the requirements of paragraph (d)(3) of this section are met, the payment provisions of § 405.465 apply.

(5) For cost reporting periods beginning after June 30, 1985, a teaching hospital that elects payment for the direct medical and surgical services of its physicians in accordance with paragraph (d)(2) of this section must remove, for purposes of calculating the per resident amounts described in § 413.86(e) of this chapter, from its graduate medical education base period costs, as defined in § 413.86(d) of this chapter, those costs relating to the supervision of interns and residents in approved programs related to the care of individual patients.

(e) Nothing in this section restricts the disposition of payments received either from Medicare or from beneficiaries.

§ 405.522 Intern and resident services in approved teaching programs.

(a) *Approved teaching programs.* Title XVIII of the Act recognizes residency programs in providers that are duly approved in their respective fields by the Accreditation Council for Graduate Medical Education of the American Medical Association, by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, by the Council on Dental Education of the American Dental Association, or, for provider cost reporting periods beginning after December 31, 1972, by the Council on Podiatric Medicine Education of the American Podiatric Medical Association.

(b) *Basis for payment.* (1) Services of interns and residents in these approved programs furnished in hospitals are explicitly excluded from the definition of "physicians' services" and are not payable as such. These services are covered as hospital services. This exclusion applies whether or not the intern or resident is authorized to practice as a physician under the laws of the State in which the intern or resident performs the services.

(2) Medicare pays for the costs of approved residency programs in hospitals and hospital-based providers as set forth in § 413.86 of this chapter. Medicare pays for the cost of the services of interns and residents,

specifically as a component of allowable costs defined by the principles of payment for provider costs set forth in § 413.85 of this chapter.

(3) For purposes of payment for services of interns and residents in accordance with these principles, recording and reporting by the hospital of the specific services furnished to individual beneficiaries is not necessary.

§ 405.523 Interns' and residents' services not in approved teaching programs.

(a) *Payment under Medicare Part B.* The services of a hospital resident or intern who is not under an approved hospital teaching program are paid to the hospital on a reasonable cost basis under Medicare Part B. Even if these services are furnished to inpatients, the cost of the services is not an allowable cost under Medicare Part A, but is allowable under Medicare Part B. For purposes of this section, these services include services of a physician employed by the hospital who is authorized to practice only in a hospital setting.

(b) *Amount of payment.* Medicare Part B payment for services discussed in paragraph (a) of this section is made to the hospital in an amount of 80 percent of the reasonable cost of services minus any applicable deductible amount. The beneficiary incurs the expense of the deductible and coinsurance amounts as determined on the basis of the hospital's charges to the beneficiary for its services that are covered under Medicare Part B.

§ 405.524 Interns' and residents' services outside the hospital.

(a) *Medicare Part A payment.* Payment is made under Medicare Part A for interns' and residents' services furnished in the following settings that meet the specified requirements:

(1) *Skilled nursing facility.* Payment to a participating NF may include the cost of services of an intern or resident who is under an approved teaching program in a hospital with which the facility has a transfer agreement that provides, in part, for the transfer of patients and the interchange of medical records.

(2) *Home health agency.* A participating home health agency may receive payment for the cost of the services of an intern or resident who is under an approved teaching program of a hospital with which the home health agency is affiliated or under common control when these services are furnished as part of the posthospital home health visits for a Medicare beneficiary. (Nevertheless, see § 413.86 of this chapter for the costs of approved

residency programs in hospital-based providers.)

(b) *Medicare Part B payment.* Medical services of a resident or intern of a hospital that are furnished by a freestanding skilled nursing facility or home health agency are paid under Medicare Part B on an 80 percent of allowable cost basis if payment is not provided under Medicare Part A.

§§ 405.530—405.533 [Removed]

6. Sections 405.530 through 405.533 are removed.

§§ 405.553, 405.555, and 405.557 [Removed]

7. The undesignated centered heading above § 405.550 and §§ 405.553, 405.555, and 405.557 are removed.

8. Sections 405.550 through 405.552, 405.554, 405.556, and 405.580 are transferred from subpart E to newly added subpart F and revised to read as follows:

Subpart F—Services of Physicians in Providers

- Sec.
- 405.550 Conditions for payment of charges for physician services to patients in providers: General provisions.
 - 405.551 Amount of payment for physician services in providers.
 - 405.552 Conditions for payment: Anesthesiology services.
 - 405.554 Conditions for payment: Radiology services.
 - 405.556 Conditions for payment: Physician laboratory services.
 - 405.580 Conditions for payment: Assistants at surgery in teaching hospitals.

Subpart F—Services of Physicians in Providers

Authority: Secs. 1102, 1814(b), 1832, 1833(a), 1834(b), 1842(b) and (h), 1848, 1861 (b) and (v), 1862(a)(14), 1866(a), 1871, 1881, 1886, 1887, and 1889 of the Social Security Act as amended (42 U.S.C. 1302, 1395f(b), 1395k, 1395l(a), 1395m(b), 1395u(b) and (h), 1395w-4, 1395x(b) and (v), 1395y(a)(14), 1395cc(a), 1395hh, 1395rr, 1395ww, 1395xx, and 1395aa).

§ 405.550 Conditions for payment of charges for physician services to patients in providers: General provisions.

(a) *Scope.* This section provides general conditions that must be met in order for services furnished by physicians in providers to be paid for on the basis of the physician fee schedule under part 415 of this chapter. Section 405.551 sets forth general requirements for determining the amounts of payment for services that meet the conditions of this section. Sections 405.552, 405.554, and 405.556 set forth additional conditions for payment for physician services in the specialties of

anesthesiology, radiology, and pathology (laboratory services).

(b) *Conditions for payment for services of physicians to provider patients.* The carrier pays for services of physicians to patients of providers on a fee schedule basis only if the following requirements are met:

(1) The services are personally furnished for an individual patient by a physician.

(2) The services contribute directly to the diagnosis or treatment of an individual patient.

(3) The services ordinarily require performance by a physician.

(4) In the case of anesthesiology, radiology, or laboratory services, the additional requirements in §§ 405.552, 405.554, or § 405.556 are met.

(c) *Services of physicians to providers.* If a physician furnishes services in a provider that do not meet the requirements in paragraph (b) of this section but are related to patient care by the provider, the intermediary will pay for those services, if otherwise covered, under the rules in §§ 405.480 and 405.481 on reasonable cost payment for physician services to providers.

(d) *Effect of billing charges for physician services in a provider—*

(1) For services performed by a physician that may be paid under the reasonable cost rules in § 405.480 or § 405.481 or would be paid under those rules except for the prospective payment rules in part 412 of this chapter, neither provider nor physician may seek charge payment from the carrier, beneficiary, or another insurer.

(2) The carrier will not pay on a fee schedule basis for services furnished by a physician to an individual patient if the services do not meet the applicable conditions in paragraph (b) of this section and §§ 405.552, 405.554, and 405.556.

(3) If the physician, the provider, or another entity bills the carrier or the beneficiary for physician services to the provider, as described in § 405.480(a), the provider in which and to which the services were furnished may be considered to have violated its provider participation agreement, and that agreement may be terminated. See part 489 of this chapter for rules governing provider agreements.

(e) *Effect of physician's assumption of operating costs.* If a physician or other entity enters into an agreement (such as a lease or concession) with a provider, under which the physician (or entity) assumes some or all of the operating costs of the provider department in which the physician furnishes physician services in the provider, the following rules apply:

(1) If the conditions set forth in paragraph (b) of this section are met, the carrier pays for the physician services under the physician fee schedule in part 415 of this chapter.

(2) To the extent the provider incurs a cost payable on a reasonable cost basis under part 413 of this chapter, the intermediary pays the provider on a reasonable cost basis for the costs associated with producing these services, including overhead, supply, and equipment costs, and services furnished by nonphysician personnel.

(3) The physician (or other entity) is treated as related to the provider within the meaning of § 413.17 of this chapter.

(4) The physician (or other entity) must make its books and records available to the provider and the intermediary as necessary to verify the nature and extent of the costs of the services furnished by the physician (or other entity).

§ 405.551 Amounts of payment for physician services in providers.

(a) *Scope.* The carrier determines amounts of payment for physician services to patients in providers in accordance with the general rules governing fee schedule payment in part 415 of this chapter, except as provided in paragraph (b) of this section.

(b) *Application in certain settings—(1) Teaching hospitals.* In determining whether fee schedule payment should be made for physician services to individual patients in a teaching hospital, the carrier applies the rules in § 405.521 in addition to those in this section.

(2) *Hospital-based ESRD facilities.* In determining the amount of payment for physician services to individual patients furnished in a hospital-based end-stage renal disease (ESRD) facility certified under subpart U of this part, the carrier applies the rules in §§ 414.310 through 414.314 of this chapter instead of those in this section.

§ 405.552 Conditions for payment: Anesthesiology services.

(a) *Services furnished directly or concurrently.* The carrier pays a physician for anesthesia services furnished to patients in a provider on a fee schedule basis only if the services meet the conditions in § 405.550(b) and the following additional conditions:

(1) For each patient, the physician—
(i) Performs a pre-anesthetic examination and evaluation;
(ii) Prescribes the anesthesia plan;
(iii) Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;

(iv) Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual as defined in program operating instructions;

(v) Monitors the course of anesthesia administration at frequent intervals;

(vi) Remains physically present and available for immediate diagnosis and treatment of emergencies; and

(vii) Provides indicated post-anesthesia care.

(2) The physician performs the procedure personally or directs no more than four anesthesia procedures concurrently and does not perform any other services while he or she is directing the concurrent procedures.

(b) *Supervision of more than four procedures concurrently.* If a physician is involved in furnishing more than four procedures concurrently, or is performing other services while directing the concurrent procedures, the concurrent anesthesia services are physician services to the provider in which the procedures are performed. In these cases, the physician is not required to meet the criteria of paragraphs (a)(1)(iii) and (vii) of this section personally, but must ensure that a qualified individual performs any procedure in which the physician does not personally participate. In these cases, the intermediary pays for the services under the rules in §§ 405.480 and 405.481 on reasonable cost payment for physician services to providers or under the rules in part 412 of this chapter for payment under the prospective payment system.

§ 405.554 Conditions for payment: Radiology services.

(a) *Services to patients.* The carrier pays for radiology services furnished by a physician to an individual patient on a fee schedule basis only if the services meet the conditions in § 405.550(b) and are identifiable, direct, and discrete diagnostic or therapeutic services to an individual patient, such as interpretation of x-ray plates, angiograms, myelograms, pyelograms, or ultrasound procedures.

(b) *Services to providers.* The carrier does not pay on a fee schedule basis for physician services to the provider (for example, administrative or supervisory services) or for provider services needed to produce the x-ray films or other items that are interpreted by the radiologist. However, the intermediary pays the provider for these services in accordance with § 405.480 for provider costs, and § 405.550(e)(2) for costs borne by a physician, such as under a lease or concession agreement, and part 412 of

this chapter for payment under the prospective payment system.

§ 405.556 Conditions for payment: Physician laboratory services.

(a) *Physician laboratory services.* The carrier pays for laboratory services furnished by a physician to an individual patient on a fee schedule basis only if the services meet the conditions for payment in § 405.550(b) and are one of the following services:

- (1) Surgical pathology services.
- (2) Specific cytopathology, hematology, and blood banking services that have been identified to require performance by a physician and are listed in program operating instructions.
- (3) Clinical consultation services that meet the requirements in paragraph (b) of this section.

(4) Clinical laboratory interpretative services that meet the requirements of paragraphs (b) (1), (3), and (4) of this section and that are specifically listed in program operating instructions.

(b) *Clinical consultation services.* For purposes of this section, clinical consultation services must meet the following requirements:

- (1) Be requested by the patient's attending physician.
- (2) Relate to a test result that lies outside the clinically significant normal or expected range in view of the condition of the patient.
- (3) Result in a written narrative report included in the patient's medical record.
- (4) Require the exercise of medical judgment by the consultant physician.

(c) *Physician laboratory services furnished by an independent laboratory.* Laboratory services, including the technical component of a service, furnished to a hospital inpatient or outpatient by an independent laboratory (as defined in § 488.52 of this chapter) are paid on a fee schedule basis under this subpart only if they are physician laboratory services as described in paragraph (a) of this section.

§ 405.580 Conditions of payment: Assistants at surgery in teaching hospitals.

(a) *Basis, purpose, and scope.* This section describes the conditions under which Medicare pays on a fee schedule basis for the services of an assistant at surgery in a teaching hospital. This section is based on section 1842(b)(6)(D)(i) of the Act and applies only to hospitals with an approved residency program. Except as specified in paragraph (c) of this section, fee schedule payment is not available for assistants at surgery in hospitals with—

- (1) A training program relating to the medical specialty required for the surgical procedure; and

(2) A qualified individual on the staff of the hospital available to serve as an assistant at surgery.

(b) *Definitions. Assistant at surgery* means a physician who actively assists the physician in charge of a case in performing a surgical procedure.

Qualified individual on the staff of the hospital means a resident in a training program relating to the specialty required for the surgery.

Teaching hospital means a hospital with a graduate medical education program approved as specified in § 405.522(a).

Team physicians means a group of physicians, each performing a discrete, unique function integral to the performance of a complex medical procedure that requires the special skills of more than one physician.

(c) *Conditions for payment for assistants at surgery.* Beginning January 1, 1992, payment on a fee schedule basis is made for the services of an assistant at surgery in a teaching hospital only if the services meet one of the following conditions:

- (1) Are required due to exceptional medical circumstances.
- (2) Are performed by team physicians needed to perform complex medical procedures.
- (3) Constitute concurrent medical care relating to a medical condition that requires the presence of, and active care by, a physician of another specialty during surgery.
- (4) Are medically required and are furnished by a physician who is primarily engaged in the field of surgery and the primary surgeon does not use interns and residents in the surgical procedures that the surgeon performs (including pre-operative and post-operative care).
- (5) Are not related to a surgical procedure for which HCFA determines that assistants are used less than 5 percent of the time.

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES

Subpart H—Payment for End-Stage Renal Disease (ESRD) Services

B. Part 413 is amended as set forth below:

1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395www); sec. 104(c) of Pub. L. 100-360 as amended by sec.

608(d)(3) of Pub. L. 100-485 (42 U.S.C. 1395ww (note)); and sec. 101(c) of Pub. L. 100-234 (42 U.S.C. 1395ww (note)).

2. In § 413.170, the section heading is revised and paragraph (c)(7) is added to read as follows:

§ 413.170 Payments for covered outpatient maintenance dialysis treatments.

(c) *Prospective rates for hospital-based and independent ESRD facilities.*

(7) In addition to the prospective payment described in this section, HCFA makes an additional payment for certain drugs furnished to ESRD patients by a Medicare-approved ESRD facility. HCFA makes this payment directly to the ESRD facility. The facility must accept the allowance determined by HCFA as payment in full. Payment for these drugs is made to the following facilities according to the methodology described:

- (i) *Hospital-based.* HCFA makes payment in accordance with the cost-reimbursement rules set forth in this part.
- (ii) *Independent.* HCFA makes payment in accordance with the methodology set forth in § 405.517 of this chapter for paying for drugs that are not paid on a cost or prospective payment basis.

C. Part 415 is added to read as follows:

PART 415—FEE SCHEDULE FOR PHYSICIANS' SERVICES

Subpart A—General Provisions

- Sec.
- 415.1 Basis and scope.
 - 415.2 Definitions.
 - 415.4 Fee schedule areas.
 - 415.20 Formula for computing payment amounts.
 - 415.22 Relative value units (RVUs).
 - 415.24 Review, revision, and addition of RVUs for physicians' services.
 - 415.26 Determining the GAF.
 - 415.28 Conversion factors.
 - 415.30 Conversion factor update.
 - 415.32 Determining payments for certain physician services furnished in outpatient hospital settings.
 - 415.34 Payment for services and supplies incident to a physician's service.
 - 415.36 Payment for drugs incident to a physician's service.
 - 415.38 Special rules for payment of low osmolar contrast media.
 - 415.40 Coding and ancillary policies.
 - 415.42 Adjustment for first 4 years of practice.
 - 415.44 Transition rules.
 - 415.46 Additional rules for payment of anesthesia services.

Sec.

- 415.48 Limits on actual charges of nonparticipating physicians.
- 415.50 Physician billing for purchased diagnostic tests.
- 415.52 Payment for physician assistants' services.
- 415.54 Payment for certified nurse-midwives' services.
- 415.56 Payment for nurse practitioners' and clinical nurse specialists' services in rural areas.
- 415.58 Payment of charges for physicians' services to patients in providers.
- 415.60 Payment for the services of certified registered nurse anesthetists.

Subpart B—[Reserved]

Authority: Secs. 1102, 1832, 1833, 1834, 1842, 1848, 1861 (b) and (s), 1862, 1866, and 1871 of the Social Security Act as amended (42 U.S.C. 1302, 1395k, 1395l, 1395m, 1395u, 1395w-4, 1395x (b) and (s), 1395y, 1395cc, and 1395rr).

Subpart A—General Provisions**§ 415.1 Basis and scope.**

This part implements the requirements of section 1848 of the Act by establishing a fee schedule for payment of physicians' services. Section 1848 requires that payment for all physicians' services otherwise payable on a reasonable charge basis be made under the physician fee schedule effective for services furnished after December 31, 1991.

§ 415.2 Definitions.

As used in this part, unless the context indicates otherwise—

AHPB stands for adjusted historical payment basis.

CF stands for conversion factor.

CY stands for calendar year.

FY stands for fiscal year.

GAF stands for geographic adjustment factor.

GPCI stands for geographic practice cost index.

HCPSCS stands for HCFA Common Procedure Coding System.

Physicians' services means the following services to the extent that they are covered by Medicare:

(1) Professional services of doctors of medicine and osteopathy (including osteopathic practitioners), doctors of optometry, doctors of podiatry, doctors of dental surgery and dental medicine, and doctors of chiropractic.

(2) Supplies and services covered "incident to" physicians' services (excluding drugs as specified in § 415.36).

(3) Outpatient physical and occupational therapy services if furnished by a person or an entity that is not a Medicare provider of services as defined in § 400.202 of this chapter.

(4) Diagnostic x-ray tests and other diagnostic tests (excluding diagnostic

laboratory tests paid under the fee schedule established under section 1833(h) of the Act).

(5) X-ray, radium, and radioactive isotope therapy, including materials and services of technicians.

RVU stands for relative value unit.

§ 415.4 Fee schedule areas.

(a) *General.* Except for the areas described in paragraph (b) of this section, HCFA establishes fee schedule areas that conform to the geographic localities in existence before January 1, 1992.

(b) *Exceptions.* HCFA establishes Statewide fee schedule areas for Nebraska, Oklahoma, and Minnesota.

(c) *Changes.* HCFA publishes a proposed notice in the **Federal Register** to announce changes to fee schedule areas and provide an opportunity for public comment. After considering public comments, HCFA publishes a final notice in the **Federal Register** to announce changes.

§ 415.20 Formula for computing payment amounts.

Under the formula set forth in section 1848(b)(1) of the Act, the fee schedule payment amount for a service defined as a "physicians' service" in section 1848(j)(3) of the Act is computed as the product of the following amounts:

(a) The relative value for the service.

(b) The geographic adjustment factor (GAF) for the fee schedule area.

(c) The conversion factor (CF).

§ 415.22 Relative value units (RVUs).

HCFA establishes RVUs for physician work, physician practice expense, and malpractice insurance.

(a) *Physician work RVUs—(1) General rule.* Physician work RVUs are established using a relative value scale in which the value of physicians' work for a particular service is rated relative to the value of work for other physicians' services.

(2) *Special RVUs for anesthesia and radiology services—(i) Anesthesia services.* The rules for determining RVUs for anesthesia services are set forth in § 415.44.

(ii) *Radiology services.* HCFA bases the RVUs for all radiology services on the relative value scale developed under section 1834(b)(1)(A) of the Act, with appropriate modifications to ensure that the RVUs established for radiology services that are similar or related to other physicians' services are consistent with the RVUs established for those similar or related services.

(b) *Practice expense RVUs.* (1) Practice expense RVUs are computed for each service or class of service by

applying average historical practice cost percentages to the estimated average allowed charge during the 1991 base period.

(2) The average practice expense percentage for a service or class of services is computed as follows:

(i) Multiply the average practice expense percentage for each specialty by the proportion of a particular service or class of service performed by that specialty.

(ii) Add the products for all specialties.

(c) *Malpractice insurance RVUs.* (1) Malpractice insurance RVUs are computed for each service or class of services by applying average malpractice insurance historical practice cost percentages to the estimated average allowed charge during the 1991 base period.

(2) The average historical malpractice insurance percentage for a service or class of services is computed as follows:

(i) Multiply the average malpractice insurance percentage for each specialty by the proportion of a particular service or class of services performed by that specialty.

(ii) Add all the products for all the specialties.

§ 415.24 Review, revision, and addition of RVUs for physicians' services.

(a) *Interim values for new and revised HCPSCS level 1 and level 2 codes.* (1) HCFA establishes interim RVUs for new services and for codes for which definitions have changed.

(2) HCFA publishes a notice in the **Federal Register** to announce interim RVUs and seek public comment on them. The RVUs are effective prospectively for services furnished beginning on the effective date specified in the notice.

(3) After considering public comments, HCFA revises, if necessary, the interim RVUs and announces those revisions in a final notice published in the **Federal Register**. Any revisions in the RVUs are effective prospectively for services furnished beginning on the effective date specified in the final notice.

(b) *Revision of RVUs for established HCPSCS level 1 and level 2 codes.* (1) HCFA publishes a proposed notice in the **Federal Register** to announce changes in RVUs for established codes and provides an opportunity for public comment no less often than every 5 years.

(2) After considering public comments, HCFA publishes a final notice in the **Federal Register** to announce revisions to RVUs.

(3) The RVU revisions are effective prospectively for services furnished beginning on the effective date specified in the final notice.

(c) *Values for local codes (HCPCS Level 3).* (1) Carriers establish relative values for local codes for services not included in HCPCS levels 1 or 2.

(2) Carriers must obtain prior approval from HCFA to establish local codes for services that meet the definition of "physician services" in § 415.2.

§ 415.26 Determining the GAF.

HCFA establishes a GAF for each service in each fee schedule area.

(a) *Geographic indices.* HCFA uses the following indices to establish the GAF:

(1) An index that reflects one-fourth of the difference between the relative value of physicians' work effort in each of the different fee schedule areas as determined under § 415.22(a) and the national average of that work effort.

(2) An index that reflects the relative costs of the mix of goods and services comprising practice expenses (other than malpractice expenses) in each of the different fee schedule areas as determined under § 415.22(b) compared to the national average of those costs.

(3) An index that reflects the relative costs of malpractice expenses in each of the different fee schedule areas as determined under § 415.22(c) compared to the national average of those costs.

(b) *Class-specific practice cost indices.* If the application of a single index to different classes of services would be substantially inequitable because of differences in the mix of goods and services comprising practice expenses for the different classes of services, more than one index may be established under paragraph (a)(2) of this section.

(c) *Computation of GAF.* The GAF for each fee schedule area is the sum of the physicians' work adjustment factor, the practice expense adjustment factor, and the malpractice cost adjustment factor, as defined in this section:

(1) The geographic physicians' work adjustment factor for a service is the product of the proportion of the total relative value for the service that reflects the RVUs for the work component and the geographic physicians' work index value established under paragraph (a)(1) of this section.

(2) The geographic practice expense adjustment factor for a service is the product of the proportion of the total relative value for the service that reflects the RVUs for the practice expense component, multiplied by the

geographic practice cost index (GPCI) value established under paragraph (a)(2) of this section.

(3) The geographic malpractice adjustment factor for a service is the product of the proportion of the total relative value for the service that reflects the RVUs for the malpractice component, multiplied by the GPCI value established under paragraph (a)(3) of this section.

§ 415.28 Conversion factors.

HCFA establishes CFs in accordance with section 1848(d) of the Act.

(a) *Base-year CFs.* HCFA established the CF for 1992 so that had section 1848 of the Act applied during 1991, it would have resulted in the same aggregate amount of payments for physicians' services as the estimated aggregate amount of these payments in 1991, adjusted by the update for 1992 computed as specified in § 415.30.

(b) *Subsequent CFs.* Beginning January 1, 1993, the CF for each year is equal to the CF for the previous year, adjusted in accordance with § 415.30.

§ 415.30 Conversion factor update.

Unless Congress acts in accordance with section 1848(d)(3) of the Act—

(a) *General rule.* The CF update for a CY equals the Medicare Economic Index increased or decreased by the number of percentage points by which the percentage increase in expenditures for physicians' services (or for a particular category of physicians' services, such as surgical services) in the second preceding FY over the third preceding FY exceeds the performance standard rate of increase established for the second preceding FY.

(b) *Downward adjustment.* The downward adjustment may not exceed the following:

- (1) For CYs 1992 and 1993, 2 percentage points.
- (2) For CYs 1994 and 1995, 2.5 percentage points.
- (3) For CY 1996 and thereafter, 3 percentage points.

§ 415.32 Determining payments for certain physician services furnished in outpatient hospital settings.

(a) *General rule.* If physician services of the type routinely furnished in physicians' offices are furnished in outpatient hospital settings, carriers determine the fee schedule amount for those services by applying the limits described in paragraph (e) of this section.

(b) *Definition.* As used in this section, "outpatient hospital settings" include the following facilities:

- (1) Hospital outpatient departments, including clinics and emergency rooms.

(2) Comprehensive outpatient rehabilitation facilities.

(c) *Services covered by limits.* HCFA establishes a list of services routinely furnished in physicians' offices nationally. Services furnished at least 50 percent of the time in physicians' offices are subject to this limit.

(d) *Services excluded from limits.* The limits established under this section do not apply to the following:

- (1) Rural health clinic services.
- (2) Surgical services included on the ambulatory surgical center list of procedures published under § 416.65(c) of this chapter.

(3) Anesthesiology services and diagnostic and therapeutic radiology services.

(e) *Limit on services in an outpatient hospital setting.* For services subject to the limit on services in an outpatient hospital setting, the carrier applies the limit by reducing the practice expense RVU for a service by 50 percent.

(f) *Application of limits.* Payment for physician services of the type described in paragraph (c) of this section that are furnished in an outpatient hospital setting is the lower of the actual charge or the payment amount determined after applying the limit to the practice expense RVU as described in paragraph (e) of this section.

§ 415.34 Payment for services and supplies incident to a physician's service.

(a) *Medical supplies.* (1) Except as otherwise specified in this paragraph, office medical supplies are considered to be part of a physician's practice expense, and payment for them is included in the practice expense portion of the payment to the physician for the medical or surgical service to which they are incidental.

(2) If physician services of the type routinely furnished in provider settings are furnished in a physician's office, separate payment may be made for certain supplies furnished incident to that physician service if the following requirements are met:

(i) It is a procedure that can safely be furnished in the office setting in appropriate circumstances.

(ii) It requires specialized supplies that are not routinely available in physicians' offices and that are generally disposable.

(3) For the purpose of paragraph (a)(2) of this section, provider settings include only the following settings:

- (i) Hospital inpatient and outpatient departments.
 - (ii) Ambulatory surgical centers.
- (4) For the purpose of paragraph (a)(2) of this section, "routinely furnished in

provider settings" means furnished in inpatient or outpatient hospital settings or ambulatory surgical centers more than 50 percent of the time.

(5) HCFA establishes a list of services for which a separate supply payment may be made under this section.

(6) The fee schedule amount for supplies billed separately is not subject to a GPCI adjustment.

(b) *Services of nonphysicians that are incident to a physician's service.* Services of nonphysicians that are covered as incident to a physician's service are paid as if the physician had personally furnished the service.

§ 415.36 Payment for drugs incident to a physician's service.

Payment for drugs incident to a physician's service is made in accordance with § 405.517 of this chapter.

§ 415.38 Special rules for payment of low osmolar contrast media.

(a) *General.* Payment for low osmolar contrast media is included in the technical component payment for diagnostic procedures except as specified in paragraph (b) of this section.

(b) *Conditions for separate payment.* For diagnostic procedures furnished to beneficiaries who are neither inpatients nor outpatients of any hospital, separate payment is made for low osmolar contrast media used in intrathecal, intravenous, and intra-arterial injections, if it is used for patients with one or more of the following characteristics:

(1) A history of a previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting.

(2) A history of asthma or allergy.

(3) Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmias, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension.

(4) Generalized severe debilitation.

(5) Sickle cell disease.

(c) *Method of payment.* If one of the conditions of paragraph (b) of this section is met, payment is made for low osmolar contrast media as set forth in § 415.36 as a drug furnished incident to a physician's service, subject to paragraph (d) of this section.

(d) *Drug payment reduction.* If separate payment is made for low osmolar contrast media, the payment amount calculated in accordance with § 415.36 is reduced by 8 percent to account for the allowance for contrast

media already included in the technical component of the diagnostic procedure code.

§ 415.40 Coding and ancillary policies.

(a) *General rule.* HCFA establishes uniform national definitions of services, codes to represent services, and payment modifiers to the codes.

(b) *Specific types of policies.* HCFA establishes uniform national ancillary policies necessary to implement the fee schedule for physicians' services. These include, but are not limited to, the following policies:

(1) Global surgery policy (for example, post- and pre-operative periods and services, and intra-operative services).

(2) Professional and technical components (for example, payment for services, such as an EEG, which typically comprise a technical component (the taking of the test) and a professional component (the interpretation)).

(3) Payment modifiers (for example, assistant-at-surgery, multiple surgery, bilateral surgery, split surgical global services, team surgery, and unusual services).

§ 415.42 Adjustment for first 4 years of practice.

(a) *General rule.* Except as specified in paragraph (b) of this section, the fee schedule payment amount must be phased in as specified in paragraph (d) of this section for physicians, physical therapists (PTs), and occupational therapists (OTs), who are in their first through fourth years of practice.

(b) *Exception.* The reduction required in paragraph (d) of this section does not apply to primary care services, as defined in section 1842(i)(4) of the Act, furnished by physicians or to services furnished by physicians, PTs, or OTs in a rural area as defined in section 1886(d)(2)(D) of the Act that is designated under section 332(a)(1)(A) of the Public Health Service Act as a Health Professional Shortage Area.

(c) *Definition of years of practice.* (1) The "first year of practice" is the first full CY during the first 6 months of which the physician, PT, or OT furnishes professional services for which payment may be made under Medicare Part B, plus any portion of the prior CY if that prior year does not meet the first 6 months test.

(2) The "second, third, and fourth years of practice" are the first, second, and third CYs following the first year of practice, respectively.

(d) *Amounts of adjustment.* The fee schedule payment for the service of a new physician, PT, or OT is limited to

the following percentages for each of the indicated years:

- (1) First year—80 percent.
- (2) Second year—85 percent.
- (3) Third year—90 percent.
- (4) Fourth year—95 percent.

§ 415.44 Transition rules.

(a) *Adjusted historical payment basis—(1) All services other than radiology and nuclear medicine services.* For all physicians' services other than radiology services, furnished in a fee schedule area, the adjusted historical payment basis (AHPB) is the estimated weighted average prevailing charge applied in the fee schedule area for the service in CY 1991, as determined by HCFA without regard to physician specialty and as adjusted to reflect payments for services below the prevailing charge, adjusted by the update established for CY 1992.

(2) *Radiology services.* For radiology services, the AHPB is the amount paid for the service in the fee schedule area in CY 1991 under the fee schedule established under section 1834(b), adjusted by the update established for CY 1992.

(3) *Nuclear medicine services.* For nuclear medicine services, the AHPB is the amount paid for the service in the fee schedule area in CY 1991 under the fee schedule established under section 6105(b) of Public Law 101-239 and section 4102(g) of Public Law 101-508, adjusted by the update established for CY 1992.

(4) *Transition adjustment.* HCFA adjusts the AHPB for all services by 5.5 percent to produce budget-neutral payments for 1992.

(b) *Adjustment of 1992 payments for physicians' services other than radiology services.* For physicians' services furnished during CY 1992 the following rules apply:

(1) If the AHPB determined under paragraph (a) of this section is from 85 percent to 115 percent of the fee schedule amount for the area for services furnished in 1992, payment is at the fee schedule amount.

(2) If the AHPB determined under paragraph (a) of this section is less than 85 percent of the fee schedule amount for the area for services furnished in 1992, an amount equal to the AHPB plus 15 percent of the fee schedule amount is substituted for the fee schedule amount.

(3) If the AHPB determined under paragraph (a) of this section is greater than 115 percent of the fee schedule amount for the area for services furnished in 1992, an amount equal to the AHPB minus 15 percent of the fee

schedule amount is substituted for the fee schedule amount.

(c) *Adjustment of 1992 payments for radiology services.* For radiology services furnished during CY 1992 the following rules apply:

(1) If the AHPB determined under paragraph (a) of this section is from 85 percent to 109 percent of the fee schedule amount for the area for services furnished in 1992, payment is at the fee schedule amount.

(2) If the AHPB determined under paragraph (a) of this section is less than 85 percent of the fee schedule amount for the area for services furnished in 1992, an amount equal to the AHPB plus 15 percent of the fee schedule amount is substituted for the fee schedule amount.

(3) If the AHPB determined under paragraph (a) of this section is greater than 109 percent of the fee schedule amount for the area for services furnished in 1992, an amount equal to the AHPB minus 9 percent of the fee schedule amount is substituted for the fee schedule amount.

(d) *Computation of payments for CY 1993.* For physicians' services subject to the transition rules in CY 1992 and furnished during CY 1993, the fee schedule is equal to 75 percent of the amount that would have been paid in the fee schedule area under the 1992 transition rules, adjusted by the amount of the 1993 update, plus 25 percent of the 1993 fee schedule amount.

(e) *Computation of payments for CY 1994.* For physicians' services subject to the transition rules in CY 1993, and furnished during CY 1994, the fee schedule is equal to 67 percent of the amount that would have been paid in the fee schedule area under the 1993 transition rules, adjusted by the amount of the 1994 update, plus 33 percent of the 1994 fee schedule amount.

(f) *Computation of payments for CY 1995.* For physicians' services subject to the transition rules in CY 1994 and furnished during CY 1995, the fee schedule is equal to 50 percent of the amount that would have been paid in the fee schedule area under the 1994 transition rules, adjusted by the amount of the 1995 update, plus 50 percent of the 1995 fee schedule amount.

§ 415.46 Additional rules for payment of anesthesia services.

(a) *Definitions.* For purposes of this section, the following definitions apply:

(1) *Base unit* means the value for each anesthesia code that reflects all activities other than anesthesia time. These activities include usual pre-operative and post-operative visits, the administration of fluids and/or blood

incident to anesthesia care, and monitoring procedures.

(2) *Time units* involve the continuous actual presence of the physician (or of the medically directed qualified anesthetist or resident) and start when he or she begins to prepare the patient for anesthesia care and ends when the anesthesiologist (or medically directed CRNA) is no longer in personal attendance, that is, when the patient may be safely placed under post-operative care.

(b) *General rules.*

(1) For physician anesthesia services furnished beginning January 1, 1992, HCFA bases payment on the lesser of the actual charge or the physician fee schedule amount in accordance with § 415.20.

(2) The physician fee schedule amount is based on the product of allowable base and time units and an anesthesia-specific CF.

(3) The allowable base units are determined by the uniform relative value guide based on the 1988 American Society of Anesthesiologists' Relative Value Guide except that the number of base units recognized for anesthesia services furnished during cataract or iridectomy surgery is four units. The uniform base units are identified in program operating instructions.

(c) *Physician personally performs the anesthesia procedure.* (1) HCFA determines the fee schedule amount for anesthesia procedures personally performed by a physician on the basis of an anesthesia-specific fee schedule CF and unreduced base units and anesthesia time units. For purposes of this paragraph, one anesthesia time unit is equivalent to 15 minutes of anesthesia time, and fractions of a 15-minute period are recognized as fractions of an anesthesia time unit.

(2) HCFA considers an anesthesia procedure to be personally performed by a physician if it meets one of the following circumstances:

(i) The physician personally performs the entire anesthesia procedure.

(ii) The physician is continuously involved in a single case involving a certified registered nurse anesthetist (CRNA), anesthesiologist assistant (AA), or student nurse anesthetist.

(iii) For services furnished before January 1, 1994, the physician establishes an attending physician relationship in one or two concurrent cases involving an intern or resident as described in § 405.521 of this chapter. HCFA pays the full fee in each of these two concurrent cases. If the physician is involved in two concurrent cases with interns or residents after December 31, 1993, the payment rules in paragraph (d)

of this section apply. (If the physician is involved in two concurrent procedures, one of which involves an intern or resident and the other a nonphysician anesthetist, the payment rules in paragraph (d) of this section apply.)

(3) No payment is made under the CRNA fee schedule for the services of a CRNA or AA involved in a procedure described in paragraph (c)(2) of this section unless HCFA determines that it was medically necessary for both the physician and the CRNA or AA to be involved in the same case.

(d) *Physician medically directs concurrent anesthesia procedures.* HCFA determines the fee schedule amount for concurrent medically directed anesthesia procedures furnished by a physician based on the anesthesia-specific fee schedule CF, reduced base units, and anesthesia time units. For purposes of this paragraph, one anesthesia time unit is equivalent to 30 minutes of anesthesia time, and fractions of a 30-minute period are recognized as fractions of an anesthesia time unit. The base unit of each concurrent medically directed anesthesia procedure furnished by a physician is reduced by the following percentages:

(1) Two procedures—10 percent.

(2) Three procedures—25 percent.

(3) Four procedures—40 percent.

(4) If cataract or iridectomy anesthesia is one of the concurrent medically directed anesthesia procedures—10 percent.

(e) *Physician medically supervises anesthesia procedures.* If the physician medically supervises more than four concurrent anesthesia procedures, HCFA bases the fee schedule amount on an anesthesia-specific CF and three base units. This represents payment for the physician's involvement in the pre-surgical anesthesia procedures.

(f) *Payment for medical or surgical services furnished by a physician while furnishing anesthesia services.* (1)

HCFA allows separate payment under the fee schedule for certain reasonable and medically necessary medical or surgical services furnished by a physician while furnishing anesthesia services to the patient. HCFA makes payment for these services in accordance with the general physician fee schedule rules in § 415.20. These services are described in program operating instructions.

(2) HCFA makes no separate payment for other medical or surgical services, such as the pre-anesthetic examination of the patient, pre- or post-operative visits, or usual monitoring functions,

that are ordinarily included in the anesthesia service.

(g) *Physician involved in multiple anesthesia services.* If the physician is involved in multiple anesthesia services for the same patient during the same operative session, the carrier makes payment according to the base unit associated with the anesthesia procedure having the highest base unit value and anesthesia time that encompasses the multiple procedures.

§ 415.48 Limits on actual charges of nonparticipating physicians.

(a) *General rule.* A nonparticipating physician who does not accept assignment may charge a beneficiary an amount up to the limiting charge described in paragraph (b) of this section.

(b) *Specific limits.* The following requirements pertain to a nonparticipating physician's limiting charge for each specified period:

(1) For CY 1991, the limiting charge is the same percentage (but no more than 40 percent for visits and consultation services and 25 percent for other services) above the 1991 prevailing charge for nonparticipating physician as the percentage by which a physician's 1990 maximum actual allowable charge (MAAC) exceeded the 1990 prevailing charge for nonparticipating physicians.

(2) For CY 1992, the limiting charge is the same percentage (but no more than 20 percent) above the 1992 fee schedule amount for nonparticipating physicians as the percentage by which the physician's 1991 limiting charge exceeded the 1991 prevailing charge for nonparticipating physicians.

(3) Beginning January 1, 1993, the limiting charge is 115 percent of the fee schedule amount for nonparticipating physicians.

§ 415.50 Physician billing for purchased diagnostic tests.

(a) *General rule.* If a physician bills for a diagnostic test performed by an outside supplier, the payment to the physician less the applicable deductibles and coinsurance may not exceed the lowest of the following amounts:

(1) The supplier's net charge to the physician.

(2) The physician's actual charge.

(3) The fee schedule amount for the test that would be allowed if the supplier billed directly.

(b) *Restriction on payment.* The physician must identify the supplier and indicate the supplier's net charge for the test. If the physician fails to provide this information, HCFA makes no payment

to the physician and the physician may not bill the beneficiary.

(1) Physicians who accept Medicare assignment may bill beneficiaries for only the applicable deductibles and coinsurance.

(2) Physicians who do not accept Medicare assignment may not bill the beneficiary more than the payment amount described in paragraph (a) of this section.

§ 415.52 Payment for physician assistants' services.

Allowed amounts for the services of a physician assistant furnished beginning January 1, 1992, may not exceed the following limits:

(a) For assistant-at-surgery services, 65 percent of the amount that would be allowed under the physician fee schedule if the assistant-at-surgery service was furnished by a physician.

(b) For services (other than assistant-at-surgery services) furnished in a hospital, 75 percent of the physician fee schedule amount for the service.

(c) For all other services, 85 percent of the physician fee schedule amount for the service.

§ 415.54 Payment for certified nurse-midwives' services.

For services furnished after December 31, 1991, allowed amounts under the fee schedule established under section 1833(a)(1)(K) of the Act for the payment of certified nurse-midwife services may not exceed 65 percent of the physician fee schedule amount for the service.

§ 415.56 Payment for nurse practitioners' and clinical nurse specialists' services.

(a) *Rural areas.* For services furnished beginning January 1, 1992, allowed amounts for the services of a nurse practitioner or a clinical nurse specialist in rural area (as described in section 1861(s)(2)(K)(iii) of the Act) may not exceed the following limits:

(1) For services furnished in a hospital (including assistant-at-surgery services), 75 percent of the physician fee schedule amount for the service.

(2) For all other services, 85 percent of the physician fee schedule amount for the service.

(b) *Non-rural areas.* For services furnished beginning January 1, 1992, allowed amounts for the services of a nurse practitioner or a clinical nurse specialist in a nursing facility may not exceed the physician fee schedule amount for the service.

§ 415.58 Payment of charges for physicians' services to patients in providers.

(a) *Payment under the physician fee schedule.* In addition to the special

conditions for payment in §§ 405.550 through 405.580 of this chapter, HCFA establishes payment for physicians' services to patients in providers under the physician fee schedule in accordance with §§ 415.1 through 415.48.

(b) *Teaching hospitals.* Services furnished by physicians in teaching hospitals may be made on a reasonable cost basis set forth in § 405.465 of this chapter if the hospital exercises the election described in § 405.521(c)(2) of this chapter.

§ 415.60 Payment for the services of certified registered nurse anesthetists.

For services furnished beginning January 1, 1992, the CF for certified registered nurse anesthetist (CRNA) services cannot exceed the CF for a service personally performed by an anesthesiologist. Medical or surgical services specifically listed in program operating instructions and furnished by a CRNA beginning January 1, 1992, are paid under the CRNA fee schedule in the same manner as physicians' services under § 415.44(d).

Subpart B—[Reserved]

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: November 8, 1991.

Gail R. Wilensky,
Administrator, Health Care Financing
Administration.

Approved: November 9, 1991.

Louis W. Sullivan,
Secretary.

Addendum A—Technical Documentation/Explanation and Guide to Use of Physician Fee Schedule Tables

As explained in the preamble to this final rule, Public Law 101-239 provides that fee schedule payment amounts¹ are the product of three elements—a relative value for the service, a geographic adjustment factor (GAF) for the fee schedule area, and a nationally uniform dollar conversion factor (CF). The law also provides for, in effect, separate adjustment of the work, practice expense, and malpractice components of the total RVUs by a GAF appropriate to that component. (As explained earlier, GPCI values are used to fulfill the statutory requirement for

¹ The amount actually payable to a physician would be 80 percent of the actual charge or 80 percent of the fee schedule payment amount, whichever is less. Also, the transition rules for 1992 through 1995 would produce different fee schedule amounts for some services in some fee schedule areas than those produced by the methodology set forth in this addendum.

GAFs.) Thus we have developed this working formula for computing a payment amount for a procedure in a fee schedule area:

$$\text{Payment} = [(RVU_w \times GPCI_w) + (RVU_{pe} \times GPCI_{pe}) + (RVU_m \times GPCI_m)] \times CF$$

where

$R\bar{V}U_w$ = physician work relative value units for the service

$R\bar{V}U_{pe}$ = practice expense relative value units for the service

$R\bar{V}U_m$ = malpractice relative value units for the service

$GPCI_w$ = geographic practice cost index value for physician work applicable in the fee schedule area²

$GPCI_{pe}$ = geographic practice cost index value for practice expense applicable in the fee schedule area

$GPCI_m$ = geographic practice cost index value for malpractice applicable in the fee schedule area

CF = uniform national conversion factor

To compute a payment amount for a

²This value reflects only one-fourth of the variation in physician work, as required by Public Law 101-239.

specific service in a particular fee schedule area using the preliminary estimates computed for this final rule, use the listing of HCPCS codes in addendum B of this final rule to locate that service. Make a note of the RVUs for work, practice expense, and malpractice for that service. Use addendum C of this final rule to obtain the work, practice expense, and malpractice geographic practice cost index (GPCI) for the particular fee schedule area.

Finally, use 31.001 as the uniform national CF for 1992. Combining the elements as specified in the formula above will yield an estimated payment amount. For example, to compute the payment amount for skin biopsy (HCPCS code 11100) in Birmingham, Alabama, first locate HCPCS code 11100 in addendum B of this final rule. The RVUs for work, practice expense, and malpractice follow:

Work RVU ($R\bar{V}U_w$) = 0.65 Practice
expense RVU ($R\bar{V}U_{pe}$) = 0.55

Malpractice RVU ($R\bar{V}U_m$) = 0.04

Next, locate Birmingham in addendum C of this final rule. The GPCI values for work, practice expense, and malpractice follow:

Work GPCI ($GPCI_w$) = 0.981

Practice expense GPCI ($GPCI_{pe}$) = 0.913

Malpractice GPCI ($GPCI_m$) = 0.824

Finally, using 31.001 as the uniform national CF, place the values into the formula provided and compute:

$$\text{Payment} = [(RVU_w \times GPCI_w) + (RVU_{pe} \times GPCI_{pe}) + (RVU_m \times GPCI_m)] \times CF$$

$$\text{Payment} = [(0.65 \times 0.981) + (0.55 \times 0.913) + (0.04 \times 0.824)] \times 31.001$$

$$\text{Payment} = [(0.638) + (0.502) + (0.033)] \times 31.001$$

$$\text{Payment} = [1.173] \times 31.001$$

$$\text{Payment} = \$36.36 \text{ (Full Fee Schedule Payment)}$$

This example does not reflect any effects of the transition rules but does reflect the payment update of 1.9 percent for 1992.

BILLING CODE 4120-03-M

ADDENDUM B

RELATIVE VALUE UNITS AND RELATED INFORMATION

This Addendum B contains the RVUs and other information for each HCPCS code in level 1 (CPT) and level 2 (alpha-numeric HCPCS), except for alpha-numeric codes beginning with B (enteral and parenteral therapy), E (durable medical equipment), or L (orthotics) and codes for anesthesiology.

1. HCPCS -- this is the CPT or level 2 HCPCS number for the service. Level 2 HCPCS codes are included at the end of this Addendum.
2. Mod (modifier if one applies) -- a modifier is shown if there are technical component (TC) and professional component (26) for the service.

If professional only (26) and TC modifiers apply, there are three entries for the code: one for the global values, one for the 26 modifier, and one for the TC modifier. Physicians should continue to bill using the code without a modifier if the physician furnishes both the professional component and TC of the service.

3. Status code. This indicator shows whether the code is in the fee schedule and whether it is separately payable if the service is covered. The presence of an "A" status does not mean that the service is covered by Medicare; carriers continue to be responsible for making coverage decisions on services in the absence of national coverage policy and in individual cases.

A = Active code. These codes are separately paid under physician fee schedule if covered. There will be RVUs for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled code. Payment for covered services are always bundled into payment for other services not specified. There will be no RVUs or payment amount for these codes and no separate payment is made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient. This service is not separately payable because it is included in the payment for other services such as hospital visits.)

- C = Carriers price the code. Carriers will establish payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.
- D = Deleted codes. These codes are deleted effective January 1, 1992.
- E = Excluded from physician fee schedule by regulation. These codes are for items and/or services that HCFA chose to exclude from fee schedule payment by regulation. No RVUs or payment amounts are shown and no payment may be made under the fee schedule for these codes. Payment for them, when covered, generally continues under reasonable charge methodology or other current payment rules.
- N = Noncovered service. These codes are noncovered services.
- P = Bundled/excluded codes. There are no RVUs and no payment amounts for these services. No separate payment should be made for them under the fee schedule.

- If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident (An example is an elastic bandage furnished by a physician incident to a physician service).

- If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (For example, colostomy supplies) and would be paid under the other payment provisions of the Act.

- T = Injections. There are RVUs and payment amounts for these services, but they are only paid when there were no other services billed on the same date by the same provider. If any other services are billed on the same date by the same provider, these services are bundled into the service(s) for which payment is made.
- V = Deleted visit code not payable under the fee schedule. There are no RVUs or payment amounts for these codes. Physicians should not bill for visits using these codes unless the date of service is before January 1, 1992.
- X = Statutory exclusion. These codes represent an item or service that is not in the statutory definition of

"physician services" for fee schedule payment purposes at section 1848(j)(3) of the Act. No RVUs or payment amounts are shown for these codes and no payment may be made under the physician fee schedule. When they are covered, payment continues under the current payment methodology (Examples are ambulance services and clinical diagnostic laboratory services).

Z = Electrocardiograms. RVUs and payment amounts are shown for these codes, but no payment may be made for these codes if they are provided during, as a result of, or in conjunction with any visit or consultation (including critical care visits and all sites of visits).

4. Description -- this is the short narrative description of the code.
5. Work RVU -- this is the relative value unit (RVU) for the physician work in the service.
6. Practice expense RVU -- this is the RVU for the practice expense for the service.
7. Malpractice RVU -- this is the RVU for the malpractice expense for the service.
8. Total RVU -- this is the sum of the work, practice expense and malpractice expense RVUs.
9. Source of work RVU -- this indicator shows the source of the work RVU in the fee schedule. As explanation of the source indicators follows:
 - 1 = Harvard physician work RVU. This RVU could be from Phase I, II, or III of the Harvard study, and could be an extrapolated or a surveyed value.
 - 2 = Physician work value established by HCFA. It may have been a refinement of a Harvard value, or a gap fill for a code for which Harvard did not provide a value. These include codes reviewed by carrier medical directors.
 - 3 = Charge based physician work RVU. This RVU was established by applying the weighted average specialty percentage for physician work for this service to the average allowed charge for the service.
10. Global period -- this indicator shows the number of days in the global period for the code (0, 10, or 90 days). An explanation of the alpha codes follows:

- XXX = The global concept does not apply to the code.
- YYY = The global period is to be set by the carrier (e.g. unlisted surgery codes).
- ZZZ = The code is part of another service and falls within the global period for the other service.

ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCCPS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
10040		A	ACNE SURGERY	1.41	0.33	0.03	1.77	2	010
10060		A	DRAINAGE OF SKIN ABSCESS	1.17	0.46	0.04	1.67	2	010
10061		A	DRAINAGE OF SKIN ABSCESS	2.61	0.68	0.06	3.35	1	010
10080		A	DRAINAGE OF PILONIDAL CYST	1.71	0.54	0.05	2.30	2	010
10081		A	DRAINAGE OF PILONIDAL CYST	2.53	1.16	0.16	3.85	1	010
10120		A	REMOVE FOREIGN BODY	1.26	0.49	0.05	1.80	1	010
10121		A	REMOVE FOREIGN BODY	2.79	1.05	0.12	3.96	1	010
10140		A	DRAINAGE OF HEMATOMA	1.44	0.51	0.05	2.00	2	010
10141		A	DRAINAGE OF HEMATOMA	2.42	0.83	0.09	3.34	1	010
10160		A	PUNCTURE DRAINAGE OF LESION	1.21	0.39	0.05	1.65	2	010
10180		A	COMPLEX DRAINAGE, WOUND	2.31	1.10	0.19	3.60	1	010
11000		A	SURGICAL CLEANSING OF SKIN	0.96	0.42	0.04	1.42	2	000
11001		A	ADDITIONAL CLEANSING OF SKIN	0.48	0.27	0.02	0.77	2	ZZZ
11040		A	SURGICAL CLEANSING, ABRASION	0.64	0.42	0.04	1.10	2	010
11041		A	SURGICAL CLEANSING OF SKIN	0.96	0.60	0.06	1.62	2	010
11042		A	CLEANSING OF SKIN/TISSUE	1.27	0.69	0.08	2.04	2	010
11043		A	CLEANSING OF TISSUE/MUSCLE	2.12	1.90	0.35	4.37	2	090
11044		A	CLEANSING TISSUE/MUSCLE/BONE	2.61	2.97	0.52	6.10	2	090
11050		A	TRIM SKIN LESION	0.45	0.38	0.03	0.86	2	000
11051		A	TRIM 2 TO 4 SKIN LESIONS	0.70	0.53	0.05	1.28	2	000
11052		A	TRIM OVER 4 SKIN LESIONS	0.91	0.43	0.04	1.38	2	000
11060		A	SHAVE SKIN LESION	0.36	0.26	0.02	0.64	2	000
11061		A	SHAVE SKIN LESIONS	0.58	0.41	0.03	1.02	2	000
11062		A	SHAVE SKIN LESIONS	0.84	0.60	0.04	1.48	2	000
11100		A	BIOPSY OF SKIN LESION	0.65	0.55	0.04	1.24	2	000
11101		A	BIOPSY, EACH ADDED LESION	0.33	0.30	0.02	0.65	2	ZZZ
11200		A	REMOVAL OF SKIN TAGS	0.73	0.45	0.04	1.22	2	010
11201		A	REMOVAL OF ADDED SKIN TAGS	0.27	0.17	0.02	0.46	2	ZZZ
11400		A	REMOVAL OF SKIN LESION	0.91	0.57	0.05	1.53	2	ZZZ
11401		A	REMOVAL OF SKIN LESION	1.34	0.71	0.06	2.11	1	010
11402		A	REMOVAL OF SKIN LESION	1.65	0.94	0.09	2.68	1	010
11403		A	REMOVAL OF SKIN LESION	1.96	1.23	0.13	3.32	1	010
11404		A	REMOVAL OF SKIN LESION	2.26	1.46	0.17	3.89	1	010
11406		A	REMOVAL OF SKIN LESION	2.86	1.99	0.34	5.19	1	010
11420		A	REMOVAL OF SKIN LESION	1.06	0.56	0.05	1.67	2	010
11421		A	REMOVAL OF SKIN LESION	1.56	0.75	0.07	2.38	1	010
11422		A	REMOVAL OF SKIN LESION	1.80	0.99	0.10	2.89	1	010
11423		A	REMOVAL OF SKIN LESION	2.23	1.38	0.15	3.76	2	010
11424		A	REMOVAL OF SKIN LESION	2.71	1.47	0.16	4.34	1	010
11426		A	REMOVAL OF SKIN LESION	3.93	1.92	0.30	6.15	1	010
11440		A	REMOVAL OF SKIN LESION	1.15	0.73	0.06	1.94	2	010
11441		A	REMOVAL OF SKIN LESION	1.65	0.90	0.08	2.63	1	010
11442		A	REMOVAL OF SKIN LESION	1.91	1.17	0.11	3.19	2	010
11443		A	REMOVAL OF SKIN LESION	2.57	1.53	0.15	4.25	1	010
11444		A	REMOVAL OF SKIN LESION	3.55	1.55	0.14	5.24	1	010
11446		A	REMOVAL OF SKIN LESION	4.68	1.87	0.19	6.74	1	010
11450		A	REMOVAL, SWEAT GLAND LESION	2.72	2.83	0.46	6.01	2	090
11451		A	REMOVAL, SWEAT GLAND LESION	3.74	3.06	0.49	7.29	2	090
11462		A	REMOVAL, SWEAT GLAND LESION	2.49	2.54	0.37	5.40	2	090
11463		A	REMOVAL, SWEAT GLAND LESION	3.31	2.11	0.35	5.77	2	090
11470		A	REMOVAL, SWEAT GLAND LESION	3.26	2.93	0.47	6.66	1	090
11471		A	REMOVAL, SWEAT GLAND LESION	4.13	2.59	0.51	7.23	1	090
11600		A	REMOVAL OF SKIN LESION	1.22	1.19	0.10	2.51	1	010
11601		A	REMOVAL OF SKIN LESION	1.98	1.47	0.12	3.57	1	010
11602		A	REMOVAL OF SKIN LESION	2.15	1.91	0.16	4.22	1	010
11603		A	REMOVAL OF SKIN LESION	2.43	2.38	0.22	5.03	1	010
11604		A	REMOVAL OF SKIN LESION	2.66	2.73	0.27	5.66	1	010
11606		A	REMOVAL OF SKIN LESION	3.23	3.27	0.52	7.02	1	010
11620		A	REMOVAL OF SKIN LESION	1.36	1.41	0.12	2.89	1	010
11621		A	REMOVAL OF SKIN LESION	2.03	1.84	0.16	4.03	1	010
11622		A	REMOVAL OF SKIN LESION	2.42	2.31	0.20	4.93	1	010
11623		A	REMOVAL OF SKIN LESION	2.86	2.72	0.26	5.84	1	010
11624		A	REMOVAL OF SKIN LESION	3.57	3.38	0.33	7.28	1	010
11626		A	REMOVAL OF SKIN LESION	4.43	3.60	0.55	8.58	1	010
11640		A	REMOVAL OF SKIN LESION	1.56	1.74	0.15	3.45	1	010
11641		A	REMOVAL OF SKIN LESION	2.35	2.20	0.19	4.74	1	010
11642		A	REMOVAL OF SKIN LESION	2.80	2.71	0.24	5.75	1	010
11643		A	REMOVAL OF SKIN LESION	3.64	3.17	0.29	7.10	1	010

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
11644		A	REMOVAL OF SKIN LESION	4.74	3.70	0.34	8.78	1	010
11646		A	REMOVAL OF SKIN LESION	6.17	4.56	0.64	11.37	1	010
11700		A	SCRAPING OF 1-5 NAILS	0.33	0.33	0.03	0.69	3	000
11701		A	SCRAPING OF ADDITIONAL NAILS	0.24	0.24	0.02	0.50	3	222
11710		A	SCRAPING OF 1-5 NAILS	0.33	0.33	0.03	0.69	3	000
11711		A	SCRAPING OF ADDITIONAL NAILS	0.20	0.20	0.02	0.42	3	222
11730		A	REMOVAL OF NAIL PLATE	1.18	0.47	0.04	1.69	2	000
11731		A	REMOVAL OF SECOND NAIL PLATE	0.39	0.55	0.05	0.99	2	222
11732		A	REMOVE ADDITIONAL NAIL PLATE	0.39	0.26	0.02	0.67	2	222
11740		A	DRAIN BLOOD FROM UNDER NAIL	0.38	0.41	0.04	0.83	2	000
11750		A	REMOVAL OF NAIL BED	1.75	2.21	0.20	4.16	1	010
11752		A	REMOVE NAIL BED/FINGER TIP	2.50	2.97	0.37	5.84	1	010
11760		A	REPAIR OF NAIL BED	1.62	0.98	0.09	2.69	1	010
11762		A	RECONSTRUCT, NAILBED W/GRAFT	2.99	2.71	0.25	5.95	1	010
11765		A	EXCISION OF NAIL FOLD, TOE	0.68	0.55	0.05	1.28	1	010
11770		A	REMOVAL OF PILONIDAL LESION	2.69	2.82	0.46	5.97	1	010
11771		A	REMOVAL OF PILONIDAL LESION	5.43	4.76	0.97	11.16	1	090
11772		A	REMOVAL OF PILONIDAL LESION	6.70	5.07	1.06	12.83	1	090
11900		A	INJECTION INTO SKIN LESIONS	0.72	0.26	0.02	1.00	1	010
11901		A	ADDED SKIN LESION INJECTIONS	1.00	0.43	0.03	1.46	2	010
11920		N	CORRECT SKIN COLOR DEFECTS	0.00	0.00	0.00	0.00		XXX
11921		N	CORRECT SKIN COLOR DEFECTS	0.00	0.00	0.00	0.00		XXX
11922		N	CORRECT SKIN COLOR DEFECTS	0.00	0.00	0.00	0.00		222
11950		N	THERAPY FOR CONTOUR DEFECTS	0.00	0.00	0.00	0.00		XXX
11951		N	THERAPY FOR CONTOUR DEFECTS	0.00	0.00	0.00	0.00		XXX
11952		N	THERAPY FOR CONTOUR DEFECTS	0.00	0.00	0.00	0.00		XXX
11954		N	THERAPY FOR CONTOUR DEFECTS	0.00	0.00	0.00	0.00		XXX
11960		A	INSERT TISSUE EXPANDER(S)	6.37	8.60	1.56	16.53	2	090
11970		A	REPLACE TISSUE EXPANDER	7.01	9.20	1.70	17.91	2	090
11971		A	REMOVE TISSUE EXPANDER(S)	1.59	4.96	0.86	7.41	2	090
11975		N	(RE)INSERT CONTRACEPTIVE CAP	0.00	0.00	0.00	0.00		XXX
11976		N	REMOVAL OF CONTRACEPTIVE CAP	0.00	0.00	0.00	0.00		XXX
12001		A	REPAIR SUPERFICIAL WOUND(S)	1.74	0.61	0.05	2.40	2	010
12002		A	REPAIR SUPERFICIAL WOUND(S)	1.90	0.83	0.07	2.80	2	010
12004		A	REPAIR SUPERFICIAL WOUND(S)	2.30	1.20	0.10	3.60	2	010
12005		A	REPAIR SUPERFICIAL WOUND(S)	2.96	1.55	0.14	4.65	1	010
12006		A	REPAIR SUPERFICIAL WOUND(S)	3.82	1.87	0.20	5.89	1	010
12007		A	REPAIR SUPERFICIAL WOUND(S)	4.29	1.89	0.20	6.38	1	010
12011		A	REPAIR SUPERFICIAL WOUND(S)	1.80	0.78	0.06	2.64	2	010
12013		A	REPAIR SUPERFICIAL WOUND(S)	2.05	1.08	0.08	3.21	2	010
12014		A	REPAIR SUPERFICIAL WOUND(S)	2.54	1.25	0.10	3.89	1	010
12015		A	REPAIR SUPERFICIAL WOUND(S)	3.30	1.71	0.14	5.15	1	010
12016		A	REPAIR SUPERFICIAL WOUND(S)	4.08	2.39	0.20	6.67	1	010
12017		A	REPAIR SUPERFICIAL WOUND(S)	4.91	3.54	0.32	8.77	1	010
12018		A	REPAIR SUPERFICIAL WOUND(S)	5.77	5.43	0.51	11.71	1	010
12020		A	CLOSURE OF SPLIT WOUND	2.71	1.26	0.19	4.16	1	010
12021		A	CLOSURE OF SPLIT WOUND	1.88	0.66	0.11	2.65	1	010
12031		A	LAYER CLOSURE OF WOUND(S)	2.21	0.76	0.07	3.04	2	010
12032		A	LAYER CLOSURE OF WOUND(S)	2.55	1.10	0.10	3.75	2	010
12034		A	LAYER CLOSURE OF WOUND(S)	3.02	1.55	0.15	4.72	1	010
12035		A	LAYER CLOSURE OF WOUND(S)	3.56	2.03	0.24	5.83	1	010
12036		A	LAYER CLOSURE OF WOUND(S)	4.21	2.45	0.38	7.04	1	010
12037		A	LAYER CLOSURE OF WOUND(S)	4.87	3.25	0.51	8.63	1	010
12041		A	LAYER CLOSURE OF WOUND(S)	2.45	0.88	0.08	3.41	2	010
12042		A	LAYER CLOSURE OF WOUND(S)	2.84	1.23	0.12	4.19	1	010
12044		A	LAYER CLOSURE OF WOUND(S)	3.25	1.71	0.17	5.13	1	010
12045		A	LAYER CLOSURE OF WOUND(S)	3.79	2.24	0.24	6.27	1	010
12046		A	LAYER CLOSURE OF WOUND(S)	4.43	2.97	0.38	7.78	1	010
12047		A	LAYER CLOSURE OF WOUND(S)	4.84	4.23	0.60	9.67	1	010
12051		A	LAYER CLOSURE OF WOUND(S)	2.55	1.06	0.10	3.71	2	010
12052		A	LAYER CLOSURE OF WOUND(S)	2.87	1.55	0.14	4.56	2	010
12053		A	LAYER CLOSURE OF WOUND(S)	3.23	1.85	0.17	5.25	1	010
12054		A	LAYER CLOSURE OF WOUND(S)	3.60	2.74	0.26	6.60	1	010
12055		A	LAYER CLOSURE OF WOUND(S)	4.62	3.42	0.38	8.42	1	010
12056		A	LAYER CLOSURE OF WOUND(S)	5.47	4.99	0.56	11.02	1	010
12057		A	LAYER CLOSURE OF WOUND(S)	6.23	5.86	0.51	12.60	1	010
13100		A	REPAIR OF WOUND OR LESION	3.23	1.20	0.13	4.56	1	010
13101		A	REPAIR OF WOUND OR LESION	4.07	2.19	0.22	6.48	1	010

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
13120		A	REPAIR OF WOUND OR LESION	3.43	1.42	0.17	5.02	1	010
13121		A	REPAIR OF WOUND OR LESION	4.52	2.80	0.34	7.66	1	010
13131		A	REPAIR OF WOUND OR LESION	3.94	2.09	0.24	6.27	1	010
13132		A	REPAIR OF WOUND OR LESION	4.44	4.81	0.46	9.71	1	010
13150		A	REPAIR OF WOUND OR LESION	3.96	1.85	0.24	6.05	1	010
13151		A	REPAIR OF WOUND OR LESION	4.64	2.58	0.36	7.58	1	010
13152		A	REPAIR OF WOUND OR LESION	6.61	5.41	0.72	12.74	1	010
13160		A	LATE CLOSURE OF WOUND	10.05	3.51	0.62	14.18	1	090
13300		A	REPAIR OF WOUND OR LESION	5.39	6.02	0.91	12.32	1	010
14000		A	SKIN TISSUE REARRANGEMENT	5.72	3.60	0.40	9.72	1	090
14001		A	SKIN TISSUE REARRANGEMENT	8.20	5.00	0.80	14.00	1	090
14020		A	SKIN TISSUE REARRANGEMENT	6.41	5.16	0.52	12.09	1	090
14021		A	SKIN TISSUE REARRANGEMENT	9.86	6.54	0.99	17.39	1	090
14040		A	SKIN TISSUE REARRANGEMENT	7.57	7.14	0.69	15.40	1	090
14041		A	SKIN TISSUE REARRANGEMENT	11.31	8.30	1.07	20.68	1	090
14060		A	SKIN TISSUE REARRANGEMENT	8.49	8.17	1.09	17.75	2	090
14061		A	SKIN TISSUE REARRANGEMENT	12.04	11.06	1.34	24.44	1	090
14300		A	SKIN TISSUE REARRANGEMENT	11.34	11.92	1.93	25.19	1	090
14350		A	SKIN TISSUE REARRANGEMENT	9.54	6.40	1.10	17.04	1	090
15000		A	SKIN GRAFT PROCEDURE	2.06	3.33	0.57	5.96	1	ZZZ
15050		A	SKIN PINCH GRAFT PROCEDURE	4.10	1.88	0.31	6.29	1	090
15100		A	SKIN SPLIT GRAFT PROCEDURE	8.49	4.78	0.94	14.21	1	090
15101		A	SKIN SPLIT GRAFT PROCEDURE	1.81	1.68	0.34	3.83	1	ZZZ
15120		A	SKIN SPLIT GRAFT PROCEDURE	9.63	6.38	0.99	17.00	1	090
15121		A	SKIN SPLIT GRAFT PROCEDURE	2.82	3.07	0.57	6.46	1	ZZZ
15200		A	SKIN FULL GRAFT PROCEDURE	7.86	4.36	0.73	12.95	1	090
15201		A	SKIN FULL GRAFT PROCEDURE	1.39	2.96	0.54	4.89	1	ZZZ
15220		A	SKIN FULL GRAFT PROCEDURE	7.82	5.09	0.89	13.80	1	090
15221		A	SKIN FULL GRAFT PROCEDURE	1.25	2.93	0.54	4.72	1	ZZZ
15240		A	SKIN FULL GRAFT PROCEDURE	8.74	6.43	1.08	16.25	1	090
15241		A	SKIN FULL GRAFT PROCEDURE	1.95	3.62	0.62	6.19	1	ZZZ
15260		A	SKIN FULL GRAFT PROCEDURE	10.08	7.86	1.04	18.98	2	090
15261		A	SKIN FULL GRAFT PROCEDURE	2.35	4.71	0.64	7.70	1	ZZZ
15350		A	SKIN HOMOGRAFT PROCEDURE	4.09	2.26	0.44	6.79	1	090
15400		A	SKIN HETEROGRAFT PROCEDURE	5.17	1.11	0.17	6.45	1	090
15410		D	SKIN FLAP TRANSPLANT	0.00	0.00	0.00	0.00		XXX
15412		D	SKIN FLAP TRANSPLANT	0.00	0.00	0.00	0.00		XXX
15414		D	SKIN FLAP TRANSPLANT	0.00	0.00	0.00	0.00		XXX
15416		D	SKIN FLAP TRANSPLANT	0.00	0.00	0.00	0.00		XXX
15500		D	FORM SKIN PEDICLE GRAFT	0.00	0.00	0.00	0.00		XXX
15505		D	FORM SKIN PEDICLE GRAFT	0.00	0.00	0.00	0.00		XXX
15510		D	FORM SKIN PEDICLE GRAFT	0.00	0.00	0.00	0.00		XXX
15515		D	FORM SKIN PEDICLE GRAFT	0.00	0.00	0.00	0.00		XXX
15540		D	ATTACH SKIN PEDICLE GRAFT	0.00	0.00	0.00	0.00		XXX
15545		D	ATTACH SKIN PEDICLE GRAFT	0.00	0.00	0.00	0.00		XXX
15550		D	ATTACH SKIN PEDICLE GRAFT	0.00	0.00	0.00	0.00		XXX
15555		D	ATTACH SKIN PEDICLE GRAFT	0.00	0.00	0.00	0.00		XXX
15570		A	FORM SKIN PEDICLE	3.95	11.36	2.19	17.50	2	090
15572		A	FORM SKIN PEDICLE	4.00	10.64	1.95	16.59	2	090
15574		A	FORM SKIN PEDICLE	4.05	10.59	1.75	16.39	2	090
15576		A	FORM SKIN PEDICLE	4.51	3.28	0.64	8.43	2	090
15580		A	CROSS FINGER FLAP	3.48	7.74	1.37	12.59	1	090
15600		A	SKIN FLAP PROCEDURE	1.79	5.18	0.93	7.90	1	090
15610		A	SKIN FLAP PROCEDURE	2.32	4.43	0.84	7.59	1	090
15620		A	SKIN FLAP PROCEDURE	2.84	5.50	0.91	9.25	1	090
15625		A	SKIN FLAP PROCEDURE	1.90	4.52	0.82	7.24	1	090
15630		A	SKIN FLAP PROCEDURE	3.18	5.80	0.95	9.93	1	090
15650		A	TRANSFER SKIN PEDICLE FLAP	3.81	5.88	0.98	10.67	1	090
15700		D	PREPARATION FOR SKIN GRAFT	0.00	0.00	0.00	0.00		XXX
15710		D	PREPARATION FOR SKIN GRAFT	0.00	0.00	0.00	0.00		XXX
15720		D	PREPARATION FOR SKIN GRAFT	0.00	0.00	0.00	0.00		XXX
15730		D	FORMATION OF DIRECT OR TUBED PED	0.00	0.00	0.00	0.00		XXX
15732		A	MUSCLE-SKIN FLAP, HEAD/NECK	12.74	20.56	3.65	36.95	2	090
15734		A	MUSCLE-SKIN FLAP, TRUNK	14.86	20.03	3.41	38.30	2	090
15736		A	MUSCLE-SKIN FLAP, ARM	10.61	7.72	1.51	19.84	2	090
15738		A	MUSCLE-SKIN FLAP, LEG	10.61	8.00	1.49	20.10	2	090
15740		A	ISLAND PEDICLE FLAP	9.97	10.96	1.71	22.64	1	090
15750		A	NEUROVASCULAR PEDICLE	11.18	12.60	2.14	25.92	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
15755		A	MICROVASCULAR FREE FLAP	29.86	31.70	5.62	67.18	1	090
15760		A	COMPOSITE SKIN GRAFT	8.72	7.68	1.16	17.56	1	090
15770		A	DERMA-FAT-FASCIA GRAFT	7.22	7.86	1.00	16.08	1	090
15775		N	HAIR TRANSPLANT PUNCH GRAFTS	0.00	0.00	0.00	0.00		XXX
15776		N	HAIR TRANSPLANT PUNCH GRAFTS	0.00	0.00	0.00	0.00		XXX
15780		A	ABRASION TREATMENT OF SKIN	7.09	1.61	0.13	8.83	1	090
15781		A	ABRASION TREATMENT OF SKIN	4.92	3.97	0.41	9.30	1	090
15782		A	ABRASION TREATMENT OF SKIN	4.42	1.25	0.13	5.80	1	090
15783		A	ABRASION TREATMENT OF SKIN	4.39	3.58	0.41	8.38	1	090
15786		A	ABRASION TREATMENT OF LESION	2.09	0.66	0.06	2.81	2	010
15787		A	ABRASION, ADDED SKIN LESIONS	0.34	0.24	0.03	0.61	1	ZZZ
15790		A	CHEMICAL PEEL, FACE	6.78	1.56	0.12	8.46	1	090
15791		A	CHEMICAL PEEL, OF SKIN	5.49	0.54	0.05	6.08	1	090
15810		A	SALABRASION	4.73	4.00	0.30	9.03	1	090
15811		A	SALABRASION	5.42	3.94	0.77	10.13	1	090
15819		A	PLASTIC SURGERY, NECK	9.35	8.45	0.92	18.72	1	090
15820		A	REVISION OF LOWER EYELID	5.05	7.14	0.68	12.87	1	090
15821		A	REVISION OF LOWER EYELID	5.66	8.52	0.72	14.90	1	090
15822		A	REVISION OF UPPER EYELID	4.51	7.56	0.60	12.67	1	090
15823		A	REVISION OF UPPER EYELID	7.01	8.13	0.65	15.79	1	090
15824		N	REMOVAL OF FOREHEAD WRINKLES	0.00	0.00	0.00	0.00		XXX
15825		N	REMOVAL OF NECK WRINKLES	0.00	0.00	0.00	0.00		XXX
15826		N	REMOVAL OF BROW WRINKLES	0.00	0.00	0.00	0.00		XXX
15828		N	REMOVAL OF FACE WRINKLES	0.00	0.00	0.00	0.00		XXX
15829		N	REMOVAL OF SKIN WRINKLES	0.00	0.00	0.00	0.00		XXX
15831		A	EXCISE EXCESSIVE SKIN TISSUE	12.29	10.37	2.12	24.78	1	090
15832		A	EXCISE EXCESSIVE SKIN TISSUE	11.56	8.73	1.40	21.69	1	090
15833		A	EXCISE EXCESSIVE SKIN TISSUE	10.55	6.55	1.17	18.27	1	090
15834		A	EXCISE EXCESSIVE SKIN TISSUE	10.71	7.57	1.29	19.57	1	090
15835		A	EXCISE EXCESSIVE SKIN TISSUE	11.57	7.38	1.29	20.24	1	090
15836		A	EXCISE EXCESSIVE SKIN TISSUE	9.31	6.11	1.15	16.57	1	090
15837		A	EXCISE EXCESSIVE SKIN TISSUE	8.52	6.30	0.89	15.71	1	090
15838		A	EXCISE EXCESSIVE SKIN TISSUE	7.15	6.20	0.77	14.12	1	090
15839		A	EXCISE EXCESSIVE SKIN TISSUE	9.40	2.57	0.49	12.46	1	090
15840		A	GRAFT FOR FACE NERVE PALSY	12.92	16.38	2.41	31.71	1	090
15841		A	GRAFT FOR FACE NERVE PALSY	22.69	17.77	2.91	43.37	1	090
15842		A	GRAFT FOR FACE NERVE PALSY	37.92	30.56	2.83	71.31	1	090
15845		A	SKIN AND MUSCLE REPAIR, FACE	12.44	17.97	2.67	33.08	1	090
15850		B	REMOVAL OF SUTURES	0.00	0.00	0.00	0.00		XXX
15851		A	REMOVAL OF SUTURES	0.91	0.31	0.03	1.25	2	000
15852		A	DRESSING CHANGE, NOT FOR BURN	0.91	0.46	0.07	1.44	2	000
15860		A	TEST FOR BLOOD FLOW IN GRAFT	2.06	1.43	0.26	3.75	2	000
15876		N	SUCTION ASSISTED LIPECTOMY	0.00	0.00	0.00	0.00		XXX
15877		N	SUCTION ASSISTED LIPECTOMY	0.00	0.00	0.00	0.00		XXX
15878		N	SUCTION ASSISTED LIPECTOMY	0.00	0.00	0.00	0.00		XXX
15879		N	SUCTION ASSISTED LIPECTOMY	0.00	0.00	0.00	0.00		XXX
15920		A	REMOVAL OF TAIL BONE ULCER	7.77	3.11	0.67	11.55	1	090
15922		A	REMOVAL OF TAIL BONE ULCER	9.66	6.31	1.25	17.22	1	090
15931		A	REMOVE SACRUM PRESSURE SORE	8.57	3.09	0.59	12.25	1	090
15933		A	REMOVE SACRUM PRESSURE SORE	10.16	7.29	1.51	18.96	1	090
15934		A	REMOVE SACRUM PRESSURE SORE	12.01	7.86	1.58	21.45	1	090
15935		A	REMOVE SACRUM PRESSURE SORE	13.75	11.84	2.40	27.99	1	090
15936		A	REMOVE SACRUM PRESSURE SORE	11.92	10.82	2.16	24.90	1	090
15937		A	REMOVE SACRUM PRESSURE SORE	13.67	14.19	2.82	30.68	1	090
15940		A	REMOVAL OF PRESSURE SORE	8.63	3.74	0.77	13.14	1	090
15941		A	REMOVAL OF PRESSURE SORE	10.70	7.43	1.47	19.60	1	090
15944		A	REMOVAL OF PRESSURE SORE	10.73	9.75	1.91	22.39	1	090
15945		A	REMOVAL OF PRESSURE SORE	11.93	11.74	2.20	25.87	1	090
15946		A	REMOVAL OF PRESSURE SORE	20.87	17.50	3.41	41.78	1	090
15950		A	REMOVE THIGH PRESSURE SORE	7.16	3.17	0.62	10.95	1	090
15951		A	REMOVE THIGH PRESSURE SORE	10.09	8.06	1.67	19.82	1	090
15952		A	REMOVE THIGH PRESSURE SORE	10.73	7.51	1.45	19.69	1	090
15953		A	REMOVE THIGH PRESSURE SORE	12.00	9.57	1.96	23.53	1	090
15954		D	REMOVE THIGH PRESSURE SORE	0.00	0.00	0.00	0.00		XXX
15955		D	REMOVE THIGH PRESSURE SORE	0.00	0.00	0.00	0.00		XXX
15956		A	REMOVE THIGH PRESSURE SORE	14.68	18.09	3.58	36.35	1	090
15958		A	REMOVE THIGH PRESSURE SORE	14.63	19.97	3.96	38.56	1	090
15960		D	REMOVE HEEL PRESSURE SORE	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
15961		D	REMOVE HEEL PRESSURE SORE	0.00	0.00	0.00	0.00		XXX
15964		D	REMOVE HEEL PRESSURE SORE	0.00	0.00	0.00	0.00		XXX
15965		D	REMOVE HEEL PRESSURE SORE	0.00	0.00	0.00	0.00		XXX
15966		D	REMOVE HEEL PRESSURE SORE	0.00	0.00	0.00	0.00		XXX
15967		D	REMOVE HEEL PRESSURE SORE	0.00	0.00	0.00	0.00		XXX
15970		D	REMOVE LEG PRESSURE SORE	0.00	0.00	0.00	0.00		XXX
15971		D	REMOVE LEG PRESSURE SORE	0.00	0.00	0.00	0.00		XXX
15972		D	REMOVE LEG PRESSURE SORE	0.00	0.00	0.00	0.00		XXX
15973		D	REMOVE LEG PRESSURE SORE	0.00	0.00	0.00	0.00		XXX
15974		D	REMOVE LEG PRESSURE SORE	0.00	0.00	0.00	0.00		XXX
15975		D	REMOVE LEG PRESSURE SORE	0.00	0.00	0.00	0.00		XXX
15980		D	REMOVE KNEE PRESSURE SORE	0.00	0.00	0.00	0.00		XXX
15981		D	REMOVE KNEE PRESSURE SORE	0.00	0.00	0.00	0.00		XXX
15982		D	REMOVE KNEE PRESSURE SORE	0.00	0.00	0.00	0.00		XXX
15983		D	REMOVE KNEE PRESSURE SORE	0.00	0.00	0.00	0.00		XXX
15999		C	REMOVAL OF PRESSURE SORE	0.00	0.00	0.00	0.00		090
16000		A	INITIAL TREATMENT OF BURN(S)	0.94	0.36	0.03	1.33	2	000
16010		A	TREATMENT OF BURN(S)	0.92	0.33	0.03	1.28	2	000
16015		A	TREATMENT OF BURN(S)	2.48	2.15	0.40	5.03	2	000
16020		A	TREATMENT OF BURN(S)	0.84	0.35	0.03	1.22	2	000
16025		A	TREATMENT OF BURN(S)	1.94	0.47	0.05	2.46	2	000
16030		A	TREATMENT OF BURN(S)	2.19	0.56	0.08	2.83	2	000
16035		A	INCISION OF BURN SCAB	4.77	1.99	0.35	7.11	1	090
17000		A	DESTRUCTION OF FACIAL LESION	0.68	0.44	0.03	1.15	2	010
17001		A	DESTRUCTION OF ADD'L LESIONS	0.20	0.20	0.02	0.42	2	222
17002		A	DESTRUCTION OF ADD'L LESIONS	0.20	0.10	0.01	0.31	2	222
17010		A	DESTRUCTION SKIN LESION(S)	1.06	0.51	0.04	1.61	2	010
17100		A	DESTRUCTION OF SKIN LESION	0.57	0.38	0.03	0.98	2	010
17101		A	DESTRUCTION OF 2ND LESION	0.11	0.19	0.02	0.32	2	222
17102		A	DESTRUCTION OF ADD'L LESIONS	0.11	0.08	0.01	0.20	2	222
17104		A	DESTRUCTION OF SKIN LESIONS	2.12	0.07	0.01	2.20	2	010
17105		A	DESTRUCTION OF SKIN LESIONS	0.80	0.32	0.03	1.15	2	010
17106		A	DESTRUCTION OF SKIN LESIONS	4.78	3.39	0.25	8.42	2	090
17107		A	DESTRUCTION OF SKIN LESIONS	9.55	6.79	0.51	16.85	2	090
17108		A	DESTRUCTION OF SKIN LESIONS	13.80	9.81	0.73	24.34	2	090
17110		A	DESTRUCTION OF SKIN LESIONS	0.59	0.42	0.03	1.04	2	010
17200		A	ELECTROCAUTERY OF SKIN TAGS	0.63	0.43	0.04	1.10	2	010
17201		A	ELECTROCAUTERY ADDED LESIONS	0.40	0.15	0.01	0.56	2	222
17250		A	CHEMICAL CAUTERY, TISSUE	0.54	0.35	0.04	0.93	2	000
17260		A	DESTRUCTION OF SKIN LESIONS	0.91	0.65	0.05	1.61	2	010
17261		A	DESTRUCTION OF SKIN LESIONS	1.17	0.83	0.06	2.06	2	010
17262		A	DESTRUCTION OF SKIN LESIONS	1.61	1.15	0.09	2.85	2	010
17263		A	DESTRUCTION OF SKIN LESIONS	1.83	1.30	0.10	3.23	2	010
17264		A	DESTRUCTION OF SKIN LESIONS	2.00	1.42	0.11	3.53	2	010
17266		A	DESTRUCTION OF SKIN LESIONS	2.42	1.72	0.13	4.27	2	010
17270		A	DESTRUCTION OF SKIN LESIONS	1.02	0.72	0.05	1.79	2	010
17271		A	DESTRUCTION OF SKIN LESIONS	1.52	1.08	0.08	2.68	2	010
17272		A	DESTRUCTION OF SKIN LESIONS	1.81	1.29	0.10	3.20	2	010
17273		A	DESTRUCTION OF SKIN LESIONS	2.14	1.52	0.11	3.77	2	010
17274		A	DESTRUCTION OF SKIN LESIONS	2.67	1.90	0.14	4.71	2	010
17276		A	DESTRUCTION OF SKIN LESIONS	3.32	2.36	0.18	5.86	2	010
17280		A	DESTRUCTION OF SKIN LESIONS	1.17	0.83	0.06	2.06	2	010
17281		A	DESTRUCTION OF SKIN LESIONS	1.76	1.25	0.09	3.10	2	010
17282		A	DESTRUCTION OF SKIN LESIONS	2.10	1.49	0.11	3.70	2	010
17283		A	DESTRUCTION OF SKIN LESIONS	2.73	1.94	0.14	4.81	2	010
17284		A	DESTRUCTION OF SKIN LESIONS	3.56	2.53	0.19	6.28	2	010
17286		A	DESTRUCTION OF SKIN LESIONS	4.63	3.29	0.24	8.16	2	010
17303		D	CHEMOSURGERY OF SKIN LESION	0.00	0.00	0.00	0.00		XXX
17304		A	CHEMOSURGERY OF SKIN LESION	5.84	4.23	0.32	10.39	2	222
17305		A	2ND STAGE CHEMOSURGERY	1.91	2.39	0.18	4.48	2	222
17306		A	3RD STAGE CHEMOSURGERY	1.91	1.48	0.11	3.50	2	222
17307		A	FOLLOWUP SKIN LESION THERAPY	1.91	1.55	0.12	3.58	2	222
17310		A	EXTENSIVE SKIN CHEMOSURGERY	0.38	0.13	0.01	0.52	2	222
17340		A	CRYOTHERAPY OF SKIN	0.77	0.29	0.02	1.08	2	010
17360		A	SKIN PEEL THERAPY	1.48	0.28	0.02	1.78	2	010
17380		N	HAIR REMOVAL BY ELECTROLYSIS	0.00	0.00	0.00	0.00		XXX
17999		C	SKIN TISSUE PROCEDURE	0.00	0.00	0.00	0.00		090
19000		A	DRAINAGE OF BREAST LESION	0.88	0.39	0.07	1.34	2	000

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
19001		A	DRAIN ADDED BREAST LESION	0.44	0.25	0.05	0.74	2	222
19020		A	INCISION OF BREAST LESION	3.55	1.48	0.29	5.32	1	090
19030		A	INJECTION FOR BREAST X-RAY	1.62	0.52	0.04	2.18	2	222
19100		A	BIOPSY OF BREAST	0.94	0.68	0.13	1.75	2	000
19101		A	BIOPSY OF BREAST	3.29	2.47	0.47	6.23	1	010
19110		A	NIPPLE EXPLORATION	4.38	2.59	0.55	7.52	1	090
19112		A	EXCISE BREAST DUCT FISTULA	3.71	2.47	0.36	6.54	1	090
19120		A	REMOVAL OF BREAST LESION	5.09	3.05	0.64	8.78	1	090
19140		A	REMOVAL OF BREAST TISSUE	5.16	4.53	0.96	10.65	1	090
19160		A	REMOVAL OF BREAST TISSUE	5.55	4.35	0.93	10.83	1	090
19162		A	REMOVE BREAST TISSUE, NODES	10.45	9.87	2.07	22.39	1	090
19180		A	REMOVAL OF BREAST	8.59	5.90	1.23	15.72	1	090
19182		A	REMOVAL OF BREAST	7.67	6.40	1.34	15.41	1	090
19200		A	REMOVAL OF BREAST	13.08	10.77	2.26	26.11	1	090
19220		A	REMOVAL OF BREAST	15.00	11.30	2.51	28.81	1	090
19240		A	REMOVAL OF BREAST	13.18	9.95	2.10	25.23	1	090
19260		A	REMOVAL OF CHEST WALL LESION	14.66	5.33	1.09	21.08	1	090
19271		A	REVISION OF CHEST WALL	17.99	14.71	2.92	35.62	1	090
19272		A	EXTENSIVE CHEST WALL SURGERY	20.52	13.28	2.70	36.50	1	090
19316		A	SUSPENSION OF BREAST	10.61	7.88	1.42	19.91	2	090
19318		A	REDUCTION OF LARGE BREAST	11.68	17.78	3.40	32.86	2	090
19324		A	ENLARGE BREAST	5.84	3.47	0.71	10.02	2	090
19325		A	ENLARGE BREAST WITH IMPLANT	8.49	6.19	1.19	15.87	2	090
19328		A	REMOVAL OF BREAST IMPLANT	5.61	3.96	0.77	10.34	1	090
19330		A	REMOVAL OF IMPLANT MATERIAL	7.57	4.08	0.79	12.44	1	090
19340		A	IMMEDIATE BREAST PROSTHESIS	6.67	11.48	2.17	20.32	1	222
19342		A	DELAYED BREAST PROSTHESIS	11.21	11.39	2.14	24.74	1	090
19350		A	BREAST RECONSTRUCTION	8.65	7.46	1.46	17.57	1	090
19355		A	CORRECT INVERTED NIPPLE(S)	7.66	5.19	1.05	13.90	1	090
19357		A	BREAST RECONSTRUCTION	17.62	12.81	2.50	32.93	2	090
19360		D	BREAST RECONSTRUCTION	0.00	0.00	0.00	0.00		XXX
19361		A	BREAST RECONSTRUCTION	14.01	10.19	1.99	26.19	2	090
19362		A	BREAST RECONSTRUCTION	28.02	20.37	3.98	52.37	2	090
19364		A	BREAST RECONSTRUCTION	29.09	17.58	3.78	50.45	1	090
19366		A	BREAST RECONSTRUCTION	20.90	17.28	3.35	41.53	1	090
19370		A	SURGERY OF BREAST CAPSULE	7.99	6.50	1.26	15.75	1	090
19371		A	REMOVAL OF BREAST CAPSULE	9.32	8.34	1.63	19.29	1	090
19380		A	REVISE BREAST RECONSTRUCTION	9.10	8.55	1.66	19.31	1	090
19396		C	DESIGN CUSTOM BREAST IMPLANT	0.00	0.00	0.00	0.00		000
19499		C	BREAST SURGERY PROCEDURE	0.00	0.00	0.00	0.00		090
20000		A	INCISION OF ABSCESS	1.94	0.89	0.08	2.91	2	010
20005		A	INCISION OF DEEP ABSCESS	3.18	1.92	0.29	5.39	2	010
20200		A	MUSCLE BIOPSY	1.54	1.17	0.19	2.90	2	000
20205		A	DEEP MUSCLE BIOPSY	2.48	1.99	0.34	4.81	2	000
20206		A	NEEDLE BIOPSY, MUSCLE	1.04	1.01	0.14	2.19	2	000
20220		A	BONE BIOPSY, TROCAR/NEEDLE	1.34	1.38	0.09	2.81	2	000
20225		A	BONE BIOPSY, TROCAR/NEEDLE	1.96	2.63	0.29	4.88	2	000
20240		A	BONE BIOPSY, EXCISIONAL	3.23	1.99	0.19	5.41	2	010
20245		A	BONE BIOPSY, EXCISIONAL	3.88	3.77	0.46	8.11	2	010
20250		A	OPEN BONE BIOPSY	4.88	5.35	0.80	11.03	2	010
20251		A	OPEN BONE BIOPSY	5.44	6.15	0.97	12.56	2	010
20500		A	INJECTION OF SINUS TRACT	1.24	0.37	0.04	1.65	2	222
20501		A	INJECT SINUS TRACT FOR X-RAY	0.80	0.31	0.02	1.13	2	222
20520		A	REMOVAL OF FOREIGN BODY	1.89	0.75	0.08	2.72	2	010
20525		A	REMOVAL OF FOREIGN BODY	3.40	2.35	0.34	6.09	2	010
20550		A	INJECT TENDON/LIGAMENT/CYST	1.22	0.40	0.04	1.66	2	010
20600		A	DRAIN/INJECT JOINT/BURSA	0.70	0.50	0.05	1.25	2	000
20605		A	DRAIN/INJECT JOINT/BURSA	0.72	0.48	0.05	1.25	2	000
20610		A	DRAIN/INJECT JOINT/BURSA	0.83	0.48	0.05	1.36	2	000
20615		A	TREATMENT OF BONE CYST	2.35	0.52	0.06	2.93	1	010
20650		A	INSERT AND REMOVE BONE PIN	2.18	1.13	0.14	3.45	2	090
20660		A	APPLY, REMOVE FIXATION DEVICE	3.18	1.65	0.22	5.05	2	090
20661		A	APPLICATION OF HEAD BRACE	4.51	4.02	0.69	9.22	2	090
20662		A	APPLICATION OF PELVIS BRACE	5.81	6.89	1.08	13.78	2	090
20663		A	APPLICATION OF THIGH BRACE	5.13	4.89	0.80	10.82	2	090
20665		A	REMOVAL OF FIXATION DEVICE	1.33	0.54	0.07	1.94	2	010
20670		A	REMOVAL OF SUPPORT IMPLANT	1.78	0.78	0.11	2.67	2	010
20680		A	REMOVAL OF SUPPORT IMPLANT	3.43	3.51	0.55	7.49	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUS	PRACTICE EXPENSE RVUS	MAL- PRACTICE RVUS	TOTAL RVUS	SOURCE OF WORK RVUS	GLOBAL FEE PERIOD
20690		A	APPLY BONE FIXATION DEVICE	3.71	3.86	0.62	8.19	2	ZZZ
20692		A	APPLY BONE FIXATION DEVICE	6.76	6.45	1.06	14.27	1	ZZZ
20693		A	ADJUST BONE FIXATION DEVICE	5.71	5.45	0.89	12.05	1	090
20694		A	REMOVE BONE FIXATION DEVICE	4.01	3.83	0.63	8.47	1	090
20802		C	REPLANTATION, ARM, COMPLETE	0.00	0.00	0.00	0.00		090
20804		C	REPLANTATION, ARM, PARTIAL	0.00	0.00	0.00	0.00		090
20805		C	REPLANT FOREARM, COMPLETE	0.00	0.00	0.00	0.00		090
20806		C	REPLANTATION, FOREARM, PARTIAL	0.00	0.00	0.00	0.00		090
20808		C	REPLANTATION, HAND, COMPLETE	0.00	0.00	0.00	0.00		090
20812		C	REPLANTATION, HAND, PARTIAL	0.00	0.00	0.00	0.00		090
20816		C	REPLANTATION DIGIT, COMPLETE	0.00	0.00	0.00	0.00		090
20820		C	REPLANTATION, DIGIT, PARTIAL	0.00	0.00	0.00	0.00		090
20822		C	REPLANTATION DIGIT, COMPLETE	0.00	0.00	0.00	0.00		090
20823		C	REPLANTATION, DIGIT, PARTIAL	0.00	0.00	0.00	0.00		090
20824		C	REPLANTATION THUMB, COMPLETE	0.00	0.00	0.00	0.00		090
20826		C	REPLANTATION, THUMB, PARTIAL	0.00	0.00	0.00	0.00		090
20827		C	REPLANTATION THUMB, COMPLETE	0.00	0.00	0.00	0.00		090
20828		C	REPLANTATION, THUMB, PARTIAL	0.00	0.00	0.00	0.00		090
20832		C	REPLANTATION, LEG, COMPLETE	0.00	0.00	0.00	0.00		090
20834		C	REPLANTATION, LEG, PARTIAL	0.00	0.00	0.00	0.00		090
20838		C	REPLANTATION, FOOT, COMPLETE	0.00	0.00	0.00	0.00		090
20840		C	REPLANTATION, FOOT, PARTIAL	0.00	0.00	0.00	0.00		090
20900		A	REMOVAL OF BONE FOR GRAFT	5.31	2.95	0.47	8.73	2	090
20902		A	REMOVAL OF BONE FOR GRAFT	7.11	5.23	0.84	13.18	1	090
20910		A	REMOVE CARTILAGE FOR GRAFT	5.31	0.83	0.09	6.23	2	090
20912		A	REMOVE CARTILAGE FOR GRAFT	6.37	4.87	0.68	11.92	2	090
20920		A	REMOVAL OF FASCIA FOR GRAFT	5.12	4.14	0.53	9.79	1	090
20922		A	REMOVAL OF FASCIA FOR GRAFT	6.37	4.63	0.75	11.75	2	090
20924		A	REMOVAL OF TENDON FOR GRAFT	6.37	5.74	0.90	13.01	2	090
20926		A	REMOVAL OF TISSUE FOR GRAFT	5.31	2.73	0.41	8.45	2	090
20950		A	RECORD FLUID PRESSURE, MUSCLE	1.33	1.14	0.18	2.65	2	000
20955		C	MICROVASCULAR FIBULA GRAFT	0.00	0.00	0.00	0.00		090
20960		C	MICROVASCULAR RIB GRAFT	0.00	0.00	0.00	0.00		090
20962		C	MICROVASCULAR BONE GRAFT	0.00	0.00	0.00	0.00		090
20969		C	BONE-SKIN GRAFT	0.00	0.00	0.00	0.00		090
20970		C	BONE-SKIN GRAFT, PELVIS	0.00	0.00	0.00	0.00		090
20971		C	BONE-SKIN GRAFT, RIB	0.00	0.00	0.00	0.00		090
20972		C	BONE-SKIN GRAFT, METATARSAL	0.00	0.00	0.00	0.00		090
20973		C	BONE-SKIN GRAFT, GREAT TOE	0.00	0.00	0.00	0.00		090
20974		A	ELECTRICAL BONE STIMULATION	0.66	3.61	0.57	4.84	2	ZZZ
20975		A	ELECTRICAL BONE STIMULATION	2.74	3.71	0.60	7.05	2	ZZZ
20999		C	MUSCULOSKELETAL SURGERY	0.00	0.00	0.00	0.00		YYY
21010		A	INCISION OF JAW JOINT	9.55	10.79	0.98	21.32	2	090
21015		A	RESECTION OF FACIAL TUMOR	5.20	6.97	0.56	12.73	2	090
21025		A	EXCISION OF BONE, LOWER JAW	5.31	4.37	0.40	10.08	2	090
21026		A	EXCISION OF FACIAL BONE(S)	4.77	3.30	0.29	8.36	2	090
21029		A	CONTOUR OF FACE BONE LESION	7.60	10.18	0.82	18.60	2	090
21030		A	REMOVAL OF FACE BONE LESION	7.43	3.53	0.30	11.26	2	090
21031		A	REMOVE EXOSTOSIS, MANDIBLE	2.12	3.88	0.33	6.33	2	090
21032		A	REMOVE EXOSTOSIS, MAXILLA	4.51	5.98	0.48	10.97	2	090
21034		A	REMOVAL OF FACE BONE LESION	15.92	7.35	0.94	24.21	2	090
21040		A	REMOVAL OF JAW BONE LESION	2.12	2.91	0.25	5.28	2	090
21041		A	REMOVAL OF JAW BONE LESION	5.31	6.07	0.54	11.92	2	090
21044		A	REMOVAL OF JAW BONE LESION	11.68	10.07	1.16	22.91	2	090
21045		A	EXTENSIVE JAW SURGERY	15.92	14.57	1.67	32.16	2	090
21050		A	REMOVAL OF JAW JOINT	10.61	12.99	1.13	24.73	2	090
21060		A	REMOVE JAW JOINT CARTILAGE	10.08	12.21	1.09	23.38	2	090
21070		A	REMOVE CORONOID PROCESS	8.07	7.18	0.86	16.11	2	090
21079		C	PREPARE FACE/ORAL PROSTHESIS	0.00	0.00	0.00	0.00		090
21080		C	PREPARE FACE/ORAL PROSTHESIS	0.00	0.00	0.00	0.00		090
21081		C	PREPARE FACE/ORAL PROSTHESIS	0.00	0.00	0.00	0.00		090
21082		C	PREPARE FACE/ORAL PROSTHESIS	0.00	0.00	0.00	0.00		090
21083		C	PREPARE FACE/ORAL PROSTHESIS	0.00	0.00	0.00	0.00		090
21084		C	PREPARE FACE/ORAL PROSTHESIS	0.00	0.00	0.00	0.00		090
21085		C	PREPARE FACE/ORAL PROSTHESIS	0.00	0.00	0.00	0.00		090
21086		C	PREPARE FACE/ORAL PROSTHESIS	0.00	0.00	0.00	0.00		090
21087		C	PREPARE FACE/ORAL PROSTHESIS	0.00	0.00	0.00	0.00		090
21088		C	PREPARE FACE/ORAL PROSTHESIS	0.00	0.00	0.00	0.00		090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
21089		C	PREPARE FACE/ORAL PROSTHESIS	0.00	0.00	0.00	0.00		090
21100		A	MAXILLOFACIAL FIXATION	4.25	1.11	0.11	5.47	2	090
21110		A	INTERDENTAL FIXATION	5.31	5.82	0.49	11.62	2	090
21116		A	INJECTION, JAW JOINT X-RAY	0.85	0.77	0.06	1.68	2	222
21120		C	RECONSTRUCTION OF CHIN	0.00	0.00	0.00	0.00		090
21121		C	RECONSTRUCTION OF CHIN	0.00	0.00	0.00	0.00		090
21122		C	RECONSTRUCTION OF CHIN	0.00	0.00	0.00	0.00		090
21123		C	RECONSTRUCTION OF CHIN	0.00	0.00	0.00	0.00		090
21125		C	AUGMENTATION LOWER JAW BONE	0.00	0.00	0.00	0.00		090
21127		C	AUGMENTATION LOWER JAW BONE	0.00	0.00	0.00	0.00		090
21137		C	REDUCTION OF FOREHEAD	0.00	0.00	0.00	0.00		090
21138		C	REDUCTION OF FOREHEAD	0.00	0.00	0.00	0.00		090
21139		C	REDUCTION OF FOREHEAD	0.00	0.00	0.00	0.00		090
21144		C	RECONSTRUCT MIDFACE, LEFORT1	0.00	0.00	0.00	0.00		090
21145		C	RECONSTRUCT MIDFACE, LEFORT1	0.00	0.00	0.00	0.00		090
21146		C	RECONSTRUCT MIDFACE, LEFORT1	0.00	0.00	0.00	0.00		090
21147		C	RECONSTRUCT MIDFACE, LEFORT1	0.00	0.00	0.00	0.00		090
21150		C	RECONSTRUCT MIDFACE, LEFORT2	0.00	0.00	0.00	0.00		090
21151		C	RECONSTRUCT MIDFACE, LEFORT2	0.00	0.00	0.00	0.00		090
21154		C	RECONSTRUCT MIDFACE, LEFORT3	0.00	0.00	0.00	0.00		090
21155		C	RECONSTRUCT MIDFACE, LEFORT3	0.00	0.00	0.00	0.00		090
21159		C	RECONSTRUCT MIDFACE, LEFORT3	0.00	0.00	0.00	0.00		090
21160		C	RECONSTRUCT MIDFACE, LEFORT3	0.00	0.00	0.00	0.00		090
21172		C	RECONSTRUCT ORBIT/FOREHEAD	0.00	0.00	0.00	0.00		090
21175		C	RECONSTRUCT ORBIT/FOREHEAD	0.00	0.00	0.00	0.00		090
21179		C	RECONSTRUCT ENTIRE FOREHEAD	0.00	0.00	0.00	0.00		090
21180		C	RECONSTRUCT ENTIRE FOREHEAD	0.00	0.00	0.00	0.00		090
21181		C	CONTOUR CRANIAL BONE LESION	0.00	0.00	0.00	0.00		090
21182		C	RECONSTRUCT CRANIAL BONE	0.00	0.00	0.00	0.00		090
21183		C	RECONSTRUCT CRANIAL BONE	0.00	0.00	0.00	0.00		090
21184		C	RECONSTRUCT CRANIAL BONE	0.00	0.00	0.00	0.00		090
21188		C	RECONSTRUCTION OF MIDFACE	0.00	0.00	0.00	0.00		090
21193		C	RECONSTRUCT LOWER JAW BONE	0.00	0.00	0.00	0.00		090
21194		C	RECONSTRUCT LOWER JAW BONE	0.00	0.00	0.00	0.00		090
21195		C	RECONSTRUCT LOWER JAW BONE	0.00	0.00	0.00	0.00		090
21196		C	RECONSTRUCT LOWER JAW BONE	0.00	0.00	0.00	0.00		090
21198		C	RECONSTRUCT LOWER JAW BONE	0.00	0.00	0.00	0.00		090
21206		C	RECONSTRUCT UPPER JAW BONE	0.00	0.00	0.00	0.00		090
21208		A	AUGMENTATION OF FACIAL BONES	10.08	11.87	1.12	23.07	2	090
21209		A	REDUCTION OF FACIAL BONES	6.61	4.83	0.80	12.24	1	090
21210		A	FACE BONE GRAFT	10.08	13.21	1.36	24.65	2	090
21215		A	LOWER JAW BONE GRAFT	10.61	16.22	1.50	28.33	2	090
21230		A	RIB CARTILAGE GRAFT	10.61	8.82	1.28	20.71	2	090
21235		A	EAR CARTILAGE GRAFT	6.61	8.85	1.14	16.60	1	090
21240		A	RECONSTRUCTION OF JAW JOINT	13.80	24.85	2.20	40.85	2	090
21242		A	RECONSTRUCTION OF JAW JOINT	12.74	16.35	1.35	30.44	2	090
21243		A	RECONSTRUCTION OF JAW JOINT	13.80	16.27	1.46	31.53	2	090
21244		A	RECONSTRUCTION OF LOWER JAW	11.68	20.14	2.04	33.86	2	090
21245		A	RECONSTRUCTION OF JAW	11.68	12.09	1.38	25.15	2	090
21246		A	RECONSTRUCTION OF JAW	18.37	23.97	1.96	44.30	1	090
21247		A	RECONSTRUCT LOWER JAW BONE	22.29	29.86	2.40	54.55	2	090
21248		A	RECONSTRUCTION OF JAW	11.68	22.67	1.84	36.19	2	090
21249		A	RECONSTRUCTION OF JAW	18.04	43.23	3.47	64.74	2	090
21255		A	RECONSTRUCT LOWER JAW BONE	16.47	22.07	1.77	40.31	2	090
21256		A	RECONSTRUCTION OF ORBIT	15.94	21.36	1.72	39.02	2	090
21260		A	REVISE EYE SOCKETS	16.27	21.80	1.75	39.82	2	090
21261		A	REVISE EYE SOCKETS	17.04	18.74	1.74	37.52	1	090
21263		A	REVISE EYE SOCKETS	27.99	37.50	3.01	68.50	1	090
21267		A	REVISE EYE SOCKETS	18.62	15.39	2.24	36.25	2	090
21268		A	REVISE EYE SOCKETS	24.10	16.17	3.29	43.56	1	090
21270		A	AUGMENTATION CHEEK BONES	12.74	10.12	1.49	24.35	2	090
21275		A	REVISION ORBITOFACIAL BONES	11.07	9.43	1.33	21.83	1	090
21280		A	REVISION OF EYELID	5.95	7.58	0.65	14.18	1	090
21282		A	REVISION OF EYELID	3.44	8.79	0.83	13.06	1	090
21295		A	REVISION OF JAW MUSCLE/BONE	1.51	1.01	0.13	2.65	1	090
21296		A	REVISION OF JAW MUSCLE/BONE	4.18	3.82	0.23	8.23	1	090
21299		C	CRANIO/MAXILLOFACIAL SURGERY	0.00	0.00	0.00	0.00		YYY
21300		A	TREATMENT OF SKULL FRACTURE	0.76	1.44	0.11	2.31	1	000

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
21310		A	TREATMENT OF NOSE FRACTURE	0.62	1.01	0.09	1.72	1	000
21315		A	TREATMENT OF NOSE FRACTURE	1.49	1.90	0.22	3.61	2	010
21320		A	TREATMENT OF NOSE FRACTURE	1.91	2.89	0.35	5.15	2	010
21325		A	REPAIR OF NOSE FRACTURE	3.71	4.31	0.56	8.58	2	090
21330		A	REPAIR OF NOSE FRACTURE	5.31	7.27	0.91	13.49	2	090
21335		A	REPAIR OF NOSE FRACTURE	8.49	13.65	1.65	23.79	2	090
21337		A	REPAIR NASAL SEPTAL FRACTURE	2.65	2.97	0.39	6.01	2	090
21338		A	REPAIR NASOETHMOID FRACTURE	6.37	5.29	0.70	12.36	1	090
21339		A	REPAIR NASOETHMOID FRACTURE	7.96	7.47	0.74	16.17	2	090
21340		A	REPAIR OF NOSE FRACTURE	10.61	9.39	1.09	21.09	2	090
21343		A	REPAIR OF SINUS FRACTURE	12.74	9.66	1.13	23.53	2	090
21345		A	REPAIR OF NOSE/JAW FRACTURE	8.03	8.33	0.85	17.21	1	090
21346		A	REPAIR OF NOSE/JAW FRACTURE	10.45	9.91	1.09	21.45	1	090
21347		A	REPAIR OF NOSE/JAW FRACTURE	12.50	10.92	1.44	24.86	1	090
21355		A	REPAIR CHEEK BONE FRACTURE	3.71	1.65	0.18	5.54	2	010
21360		A	REPAIR CHEEK BONE FRACTURE	6.37	7.67	0.94	14.98	2	090
21365		A	REPAIR CHEEK BONE FRACTURE	14.73	13.01	1.72	29.46	1	090
21385		A	REPAIR EYE SOCKET FRACTURE	9.02	10.11	1.19	20.32	2	090
21386		A	REPAIR EYE SOCKET FRACTURE	9.02	9.56	1.32	19.90	2	090
21387		A	REPAIR EYE SOCKET FRACTURE	9.56	7.85	1.01	18.42	1	090
21390		A	REPAIR EYE SOCKET FRACTURE	9.99	12.53	1.45	23.97	1	090
21395		A	REPAIR EYE SOCKET FRACTURE	12.49	10.15	1.45	24.09	1	090
21400		A	TREAT EYE SOCKET FRACTURE	1.38	1.35	0.14	2.87	2	090
21401		A	REPAIR EYE SOCKET FRACTURE	3.21	2.72	0.33	6.26	1	090
21406		A	REPAIR EYE SOCKET FRACTURE	6.90	5.49	0.78	13.17	2	090
21407		A	REPAIR EYE SOCKET FRACTURE	8.49	7.47	0.82	16.78	2	090
21421		A	TREAT MOUTH ROOF FRACTURE	5.05	6.88	0.66	12.59	1	090
21422		A	REPAIR MOUTH ROOF FRACTURE	8.20	10.33	1.26	19.79	1	090
21431		A	TREAT CRANIOFACIAL FRACTURE	6.94	6.35	0.75	14.04	1	090
21432		A	REPAIR CRANIOFACIAL FRACTURE	8.49	7.13	0.88	16.50	2	090
21433		A	REPAIR CRANIOFACIAL FRACTURE	11.68	10.39	1.26	23.33	2	090
21435		A	REPAIR CRANIOFACIAL FRACTURE	16.98	13.97	1.97	32.92	2	090
21440		A	REPAIR DENTAL RIDGE FRACTURE	2.65	3.22	0.28	6.15	2	090
21445		A	REPAIR DENTAL RIDGE FRACTURE	5.31	6.44	0.60	12.35	2	090
21450		A	TREAT LOWER JAW FRACTURE	2.93	2.99	0.27	6.19	1	090
21451		A	TREAT LOWER JAW FRACTURE	4.79	7.98	0.78	13.55	1	090
21452		A	TREAT LOWER JAW FRACTURE	1.59	1.55	0.16	3.30	2	090
21453		A	TREAT LOWER JAW FRACTURE	3.18	3.80	0.32	7.30	2	090
21454		A	TREAT LOWER JAW FRACTURE	6.37	15.45	1.50	23.32	2	090
21455		A	REPAIR LOWER JAW FRACTURE	6.37	9.08	0.85	16.30	2	090
21461		A	REPAIR LOWER JAW FRACTURE	7.96	13.37	1.37	22.70	2	090
21462		A	REPAIR LOWER JAW FRACTURE	9.64	14.15	1.41	25.20	1	090
21465		A	REPAIR LOWER JAW FRACTURE	6.61	8.06	0.76	15.43	1	090
21470		A	REPAIR LOWER JAW FRACTURE	14.96	18.05	1.83	34.84	1	090
21480		A	RESET DISLOCATED JAW	0.65	1.10	0.09	1.84	1	000
21485		A	RESET DISLOCATED JAW	2.02	2.30	0.21	4.53	1	090
21490		A	REPAIR DISLOCATED JAW	5.33	6.64	0.56	12.53	1	090
21493		A	TREAT HYOID BONE FRACTURE	1.25	1.68	0.13	3.06	1	090
21494		A	REPAIR HYOID BONE FRACTURE	6.19	8.29	0.67	15.15	1	090
21495		A	REPAIR HYOID BONE FRACTURE	5.61	5.07	0.55	11.23	1	090
21497		A	INTERDENTAL WIRING	3.81	4.18	0.40	8.39	1	090
21499		C	HEAD SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
21501		A	DRAIN NECK/CHEST LESION	3.71	1.91	0.27	5.89	2	090
21502		A	DRAIN CHEST LESION	6.79	4.45	0.79	12.03	1	090
21510		A	DRAINAGE OF BONE LESION	5.31	4.02	0.54	9.87	2	090
21550		A	BIOPSY OF NECK/CHEST	2.12	0.89	0.12	3.13	2	010
21555		A	REMOVE LESION NECK/CHEST	4.31	1.69	0.26	6.26	1	090
21556		A	REMOVE LESION NECK/CHEST	5.56	4.00	0.68	10.24	1	090
21557		A	REMOVE TUMOR, NECK OR CHEST	9.02	8.95	1.49	19.46	2	090
21600		A	PARTIAL REMOVAL OF RIB	6.60	4.74	0.93	12.27	1	090
21610		A	PARTIAL REMOVAL OF RIB	6.30	5.45	0.80	12.55	1	090
21615		A	REMOVAL OF RIB	9.51	10.67	2.07	22.25	1	090
21616		A	REMOVAL OF RIB AND NERVES	11.71	7.65	1.58	20.94	1	090
21620		A	PARTIAL REMOVAL OF STERNUM	6.37	7.22	1.30	14.89	2	090
21627		A	STERNAL DEBRIDEMENT	4.25	5.31	0.95	10.51	2	090
21630		A	EXTENSIVE STERNUM SURGERY	16.41	11.81	2.15	30.37	1	090
21632		A	EXTENSIVE STERNUM SURGERY	17.51	12.16	2.34	32.01	2	090
21633		A	EXTENSIVE STERNUM SURGERY	10.61	13.79	2.58	26.98	2	090

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ADDENDUM B
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HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
21700		A	REVISION OF NECK MUSCLE	6.16	4.39	0.53	11.08	1	090
21705		A	REVISION OF NECK MUSCLE/RIB	9.51	5.10	1.01	15.62	2	090
21720		A	REVISION OF NECK MUSCLE	5.73	4.04	0.56	10.33	1	090
21725		A	REVISION OF NECK MUSCLE	6.90	5.09	0.78	12.77	2	090
21740		A	RECONSTRUCTION OF STERNUM	12.74	9.47	1.73	23.94	2	090
21750		A	REPAIR OF STERNUM SEPARATION	10.61	7.72	1.51	19.84	2	090
21800		A	TREATMENT OF RIB FRACTURE	0.96	0.81	0.07	1.84	2	090
21805		A	TREATMENT OF RIB FRACTURE	2.76	1.42	0.17	4.35	2	090
21810		A	TREATMENT OF RIB FRACTURE(S)	7.04	7.72	0.65	15.41	1	090
21820		A	TREAT STERNUM FRACTURE	1.27	1.44	0.17	2.88	2	090
21825		A	REPAIR STERNUM FRACTURE	7.19	7.27	1.17	15.63	1	090
21899		C	NECK/CHEST SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
21920		A	BIOPSY SOFT TISSUE OF BACK	2.12	0.83	0.11	3.06	1	010
21925		A	BIOPSY SOFT TISSUE OF BACK	4.46	2.06	0.33	6.85	2	090
21930		A	REMOVE LESION, BACK OR FLANK	6.90	2.87	0.52	10.29	2	090
21935		A	REMOVE TUMOR OF BACK	18.04	6.94	1.37	26.35	2	090
22100		A	REMOVE PART OF NECK VERTEBRA	8.63	6.71	0.87	16.21	1	090
22101		A	REMOVE PART, THORAX VERTEBRA	8.63	6.92	1.26	16.81	1	090
22102		A	REMOVE PART, LUMBAR VERTEBRA	9.26	4.62	0.66	14.54	1	090
22105		A	REMOVE PART OF NECK VERTEBRA	13.71	11.35	1.81	26.87	1	090
22106		A	REMOVE PART, THORAX VERTEBRA	12.21	9.73	1.61	23.55	2	090
22107		A	REMOVE PART, LUMBAR VERTEBRA	12.21	5.16	0.88	18.25	2	090
22110		A	REMOVE PART OF NECK VERTEBRA	12.21	10.24	1.73	24.18	2	090
22112		A	REMOVE PART, THORAX VERTEBRA	12.21	10.43	1.72	24.36	2	090
22114		A	REMOVE PART, LUMBAR VERTEBRA	12.21	7.64	1.23	21.08	2	090
22140		A	RECONSTRUCT NECK SPINE	23.39	17.84	2.88	44.11	1	090
22141		A	RECONSTRUCT THORAX SPINE	26.81	18.15	2.93	47.89	1	090
22142		A	RECONSTRUCT LUMBAR SPINE	26.81	22.73	3.37	52.91	2	090
22145		A	RECONSTRUCT VERTEBRA(E)	7.07	7.22	1.14	15.43	1	222
22148		A	HARVESTING BONE GRAFT	3.18	5.02	0.86	9.06	2	222
22150		A	RECONSTRUCT NECK SPINE	23.35	18.49	2.91	44.75	2	090
22151		A	RECONSTRUCT THORAX SPINE	23.35	18.60	3.42	45.37	2	090
22152		A	RECONSTRUCT LUMBAR SPINE	23.35	19.32	3.43	46.10	2	090
22210		A	REVISION OF NECK SPINE	19.11	14.57	2.56	36.24	2	090
22212		A	REVISION OF THORAX SPINE	19.11	18.22	2.98	40.31	2	090
22214		A	REVISION OF LUMBAR SPINE	19.11	15.92	2.83	37.86	2	090
22220		A	REVISION OF NECK SPINE	21.23	17.54	2.78	41.55	2	090
22222		A	REVISION OF THORAX SPINE	21.23	14.34	1.67	37.24	2	090
22224		A	REVISION OF LUMBAR SPINE	21.23	15.47	2.81	39.51	2	090
22230		A	ADDITIONAL REVISION OF SPINE	6.37	5.35	0.94	12.66	2	222
22305		A	TREAT SPINE PROCESS FRACTURE	1.95	2.75	0.38	5.08	2	090
22310		A	TREAT SPINE FRACTURE	1.95	4.78	0.73	7.46	2	090
22315		A	TREAT SPINE FRACTURE	8.81	5.80	0.91	15.52	1	090
22325		A	REPAIR OF SPINE FRACTURE	18.11	8.76	1.41	28.28	1	090
22326		A	REPAIR NECK SPINE FRACTURE	19.42	16.79	2.89	39.10	1	090
22327		A	REPAIR THORAX SPINE FRACTURE	18.50	16.81	2.48	37.79	1	090
22505		A	MANIPULATION OF SPINE	1.86	1.38	0.18	3.42	2	010
22548		A	NECK SPINE FUSION	25.38	23.96	4.02	53.36	1	090
22554		A	NECK SPINE FUSION	19.11	20.87	3.71	43.69	2	090
22556		A	THORAX SPINE FUSION	24.42	22.85	3.78	51.05	1	090
22558		A	LUMBAR SPINE FUSION	23.31	21.25	3.56	48.12	1	090
22585		A	ADDITIONAL SPINAL FUSION	5.82	5.69	0.98	12.49	1	222
22590		A	SPINE & SKULL SPINAL FUSION	19.98	22.73	3.63	46.34	1	090
22595		A	NECK SPINAL FUSION	20.27	23.67	4.07	48.01	1	090
22600		A	NECK SPINE FUSION	19.02	20.41	3.50	42.93	1	090
22610		A	THORAX SPINE FUSION	15.92	18.83	2.90	37.65	2	090
22612		A	LUMBAR SPINE FUSION	16.98	20.25	3.25	40.48	2	090
22625		A	LUMBAR SPINE FUSION	20.98	23.10	3.75	47.83	1	090
22630		A	LUMBAR SPINE FUSION	22.05	19.44	3.31	44.80	1	090
22650		A	ADDITIONAL SPINAL FUSION	6.79	5.96	0.97	13.72	1	222
22800		A	FUSION OF SPINE	17.84	23.62	3.77	45.23	1	090
22802		A	FUSION OF SPINE	22.58	29.85	4.85	57.28	1	090
22810		A	FUSION OF SPINE	23.35	19.40	3.32	46.07	2	090
22812		A	FUSION OF SPINE	28.66	27.33	4.47	60.46	2	090
22820		A	HARVESTING OF BONE	2.94	4.75	0.78	8.47	2	222
22830		A	EXPLORATION OF SPINAL FUSION	10.77	13.95	2.29	27.01	1	090
22840		A	INSERT SPINE FIXATION DEVICE	13.22	23.92	3.83	40.97	2	222
22842		A	INSERT SPINE FIXATION DEVICE	15.19	26.18	4.23	45.60	2	222

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
22845		A	INSERT SPINE FIXATION DEVICE	13.16	20.10	3.45	36.71	2	222
22849		A	REINSERT SPINAL FIXATION	13.55	12.40	2.08	28.03	1	090
22850		A	REMOVE SPINE FIXATION DEVICE	9.46	9.66	1.58	20.70	1	090
22852		A	REMOVE SPINE FIXATION DEVICE	8.85	10.33	1.66	20.84	1	090
22855		A	REMOVE SPINE FIXATION DEVICE	9.59	7.86	1.32	18.77	1	090
22899		C	SPINE SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
22900		A	REMOVE ABDOMINAL WALL LESION	6.91	3.19	0.64	10.74	1	090
22999		C	ABDOMEN SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
23000		A	REMOVAL OF CALCIUM DEPOSITS	4.34	3.42	0.50	8.26	1	090
23020		A	RELEASE SHOULDER JOINT	8.69	7.66	1.14	17.49	1	090
23030		A	DRAIN SHOULDER LESION	3.33	2.27	0.36	5.96	2	010
23031		A	DRAIN SHOULDER BURSA	2.84	0.53	0.05	3.42	2	010
23035		A	DRAIN SHOULDER BONE LESION	8.22	6.55	1.09	15.86	1	090
23040		A	EXPLORATORY SHOULDER SURGERY	8.84	9.76	1.55	20.15	1	090
23044		A	EXPLORATORY SHOULDER SURGERY	6.75	7.28	1.24	15.27	1	090
23065		A	BIOPSY SHOULDER TISSUES	2.36	0.70	0.09	3.15	1	010
23066		A	BIOPSY SHOULDER TISSUES	4.22	1.24	0.10	5.56	1	090
23075		A	REMOVAL OF SHOULDER LESION	2.47	1.77	0.30	4.54	1	010
23076		A	REMOVAL OF SHOULDER LESION	7.50	3.73	0.69	11.92	1	090
23077		A	REMOVE TUMOR OF SHOULDER	15.43	7.78	1.46	24.67	1	090
23100		A	BIOPSY OF SHOULDER JOINT	5.94	8.18	1.31	15.43	1	090
23101		A	SHOULDER JOINT SURGERY	5.49	7.74	1.28	14.51	1	090
23105		A	REMOVE SHOULDER JOINT LINING	8.16	11.02	1.82	21.00	1	090
23106		A	INCISION OF COLLARBONE JOINT	5.85	5.00	0.84	11.69	1	090
23107		A	EXPLORE,TREAT SHOULDER JOINT	8.57	10.11	1.69	20.37	1	090
23120		A	PARTIAL REMOVAL, COLLARBONE	7.01	4.86	0.78	12.65	1	090
23125		A	REMOVAL OF COLLARBONE	9.38	8.94	1.34	19.66	1	090
23130		A	PARTIAL REMOVAL,SHOULDERBONE	7.48	7.43	1.20	16.11	1	090
23140		A	REMOVAL OF BONE LESION	6.78	4.39	0.77	11.94	1	090
23145		A	REMOVAL OF BONE LESION	8.99	8.57	1.40	18.96	1	090
23146		A	REMOVAL OF BONE LESION	7.74	5.51	1.06	14.31	1	090
23150		A	REMOVAL OF HUMERUS LESION	8.22	6.99	1.06	16.27	1	090
23155		A	REMOVAL OF HUMERUS LESION	10.10	9.28	1.45	20.83	1	090
23156		A	REMOVAL OF HUMERUS LESION	8.43	8.04	1.32	17.79	1	090
23170		A	REMOVE COLLARBONE LESION	6.60	5.06	0.82	12.48	1	090
23172		A	REMOVE SHOULDER BLADE LESION	6.57	5.44	0.77	12.78	1	090
23174		A	REMOVE HUMERUS LESION	9.19	9.01	1.28	19.48	1	090
23180		A	REMOVE COLLARBONE LESION	8.24	4.54	0.71	13.49	1	090
23182		A	REMOVE SHOULDERBLADE LESION	7.84	6.92	1.18	15.94	1	090
23184		A	REMOVE HUMERUS LESION	9.07	9.31	1.56	19.94	1	090
23190		A	PARTIAL REMOVAL OF SCAPULA	7.15	6.40	1.03	14.58	1	090
23195		A	REMOVAL OF HEAD OF HUMERUS	9.48	9.39	1.53	20.40	1	090
23200		A	REMOVAL OF COLLARBONE	11.64	9.66	1.33	22.63	1	090
23210		A	REMOVAL OF SHOULDERBLADE	12.00	9.49	1.49	22.98	1	090
23220		A	PARTIAL REMOVAL OF HUMERUS	14.03	12.69	2.14	28.86	1	090
23221		A	PARTIAL REMOVAL OF HUMERUS	17.51	19.10	1.25	37.86	1	090
23222		A	PARTIAL REMOVAL OF HUMERUS	17.54	15.83	2.43	35.80	1	090
23330		A	REMOVE SHOULDER FOREIGN BODY	1.89	0.59	0.07	2.55	1	010
23331		A	REMOVE SHOULDER FOREIGN BODY	7.26	2.39	0.40	10.05	1	090
23332		A	REMOVE SHOULDER FOREIGN BODY	11.16	10.25	1.66	23.07	1	090
23350		A	INJECTION FOR SHOULDER X-RAY	1.05	0.56	0.05	1.66	2	222
23395		A	MUSCLE TRANSFER, SHOULDER/ARM	13.09	11.73	1.93	26.75	1	090
23397		A	MUSCLE TRANSFERS	16.05	14.73	2.47	33.25	1	090
23400		A	FIXATION OF SHOULDERBLADE	13.65	10.37	1.77	25.79	1	090
23405		A	INCISION OF TENDON & MUSCLE	8.40	7.89	1.04	17.33	1	090
23406		A	INCISE TENDON(S) & MUSCLE(S)	10.88	9.92	1.67	22.47	1	090
23410		A	REPAIR OF TENDON(S)	12.54	11.53	1.84	25.91	1	090
23412		A	REPAIR OF TENDON(S)	13.37	14.09	2.27	29.73	1	090
23415		A	RELEASE OF SHOULDER LIGAMENT	10.03	5.46	0.87	16.36	1	090
23420		A	REPAIR OF SHOULDER	13.28	15.47	2.47	31.22	1	090
23430		A	REPAIR BICEPS TENDON RUPTURE	10.08	7.74	1.25	19.07	1	090
23440		A	REMOVAL/TRANSPLANT TENDON	10.62	7.56	1.23	19.41	1	090
23450		A	REPAIR SHOULDER CAPSULE	13.54	13.43	2.15	29.12	1	090
23455		A	REPAIR SHOULDER CAPSULE	14.56	16.40	2.63	33.59	1	090
23460		A	REPAIR SHOULDER CAPSULE	15.45	14.83	2.36	32.64	1	090
23462		A	REPAIR SHOULDER CAPSULE	15.40	15.94	2.61	33.95	1	090
23465		A	REPAIR SHOULDER CAPSULE	15.95	14.92	2.40	33.27	1	090
23466		A	REPAIR SHOULDER CAPSULE	14.38	13.77	2.05	30.20	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
23470		A	RECONSTRUCT SHOULDER JOINT	16.98	17.66	2.80	37.44	1	090
23472		A	RECONSTRUCT SHOULDER JOINT	16.95	32.24	5.15	54.34	1	090
23480		A	REVISION OF COLLARBONE	11.13	6.94	1.07	19.14	1	090
23485		A	REVISION OF COLLARBONE	13.36	12.74	2.09	28.19	1	090
23490		A	REINFORCE CLAVICLE	11.92	10.51	0.84	23.27	1	090
23491		A	REINFORCE SHOULDER BONES	14.36	13.38	2.22	29.96	1	090
23500		A	TREAT CLAVICLE FRACTURE	2.06	1.74	0.22	4.02	2	090
23505		A	TREAT CLAVICLE FRACTURE	3.73	2.71	0.40	6.84	1	090
23510		A	REPAIR CLAVICLE FRACTURE	5.47	5.51	0.67	11.65	1	090
23515		A	REPAIR CLAVICLE FRACTURE	7.39	7.30	1.17	15.86	1	090
23520		A	TREAT CLAVICLE DISLOCATION	2.14	1.46	0.20	3.80	2	090
23525		A	TREAT CLAVICLE DISLOCATION	3.59	2.09	0.28	5.96	1	090
23530		A	REPAIR CLAVICLE DISLOCATION	7.40	6.93	0.96	15.29	1	090
23532		A	REPAIR CLAVICLE DISLOCATION	7.99	7.62	1.25	16.86	1	090
23540		A	TREAT CLAVICLE DISLOCATION	2.21	1.64	0.20	4.05	2	090
23545		A	TREAT CLAVICLE DISLOCATION	3.23	2.09	0.30	5.62	1	090
23550		A	REPAIR CLAVICLE DISLOCATION	7.01	9.31	1.54	17.86	1	090
23552		A	REPAIR CLAVICLE DISLOCATION	8.25	7.68	1.23	17.16	1	090
23570		A	TREAT SHOULDERBLADE FRACTURE	2.21	1.79	0.26	4.26	2	090
23575		A	TREAT SHOULDERBLADE FRACTURE	4.08	2.90	0.45	7.43	1	090
23580		A	REPAIR SCAPULA FRACTURE	5.18	5.31	0.66	11.15	1	090
23585		A	REPAIR SCAPULA FRACTURE	8.86	8.12	1.36	18.34	1	090
23600		A	TREAT HUMERUS FRACTURE	2.90	3.06	0.45	6.41	2	090
23605		A	TREAT HUMERUS FRACTURE	4.80	5.01	0.80	10.61	1	090
23610		A	REPAIR HUMERUS FRACTURE	6.02	5.48	0.89	12.39	1	090
23615		A	REPAIR HUMERUS FRACTURE	8.83	11.63	1.87	22.33	1	090
23620		A	TREAT HUMERUS FRACTURE	2.37	3.29	0.49	6.15	2	090
23625		A	TREAT HUMERUS FRACTURE	3.84	4.02	0.64	8.50	1	090
23630		A	REPAIR HUMERUS FRACTURE	7.26	9.30	1.48	18.04	1	090
23650		A	TREAT SHOULDER DISLOCATION	3.42	2.21	0.25	5.88	1	090
23655		A	TREAT SHOULDER DISLOCATION	4.50	3.09	0.46	8.05	1	090
23658		A	REPAIR SHOULDER DISLOCATION	6.36	6.28	0.90	13.54	1	090
23660		A	REPAIR SHOULDER DISLOCATION	7.47	9.56	1.48	18.51	1	090
23665		A	TREAT DISLOCATION/FRACTURE	4.39	3.53	0.55	8.47	1	090
23670		A	REPAIR DISLOCATION/FRACTURE	7.84	11.92	1.94	21.70	1	090
23675		A	TREAT DISLOCATION/FRACTURE	5.89	4.14	0.65	10.68	1	090
23680		A	REPAIR DISLOCATION/FRACTURE	9.96	13.89	2.24	26.09	1	090
23700		A	FIXATION OF SHOULDER	2.60	2.20	0.35	5.15	2	010
23800		A	FUSION OF SHOULDER JOINT	14.04	17.23	2.78	34.05	1	090
23802		A	FUSION OF SHOULDER JOINT	15.46	14.83	2.36	32.65	1	090
23900		A	AMPUTATION OF ARM & GIRDLE	19.39	13.25	2.53	35.17	2	090
23920		A	AMPUTATION AT SHOULDER JOINT	14.33	14.59	2.67	31.59	2	090
23921		A	AMPUTATION FOLLOW-UP SURGERY	5.31	4.51	0.78	10.60	2	090
23929		C	SHOULDER SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
23930		A	DRAINAGE OF ARM LESION	2.93	1.70	0.25	4.88	2	010
23931		A	DRAINAGE OF ARM BURSA	1.72	0.79	0.11	2.62	1	010
23935		A	DRAIN ARM/ELBOW BONE LESION	5.85	4.94	0.82	11.61	1	090
24000		A	EXPLORATORY ELBOW SURGERY	5.61	9.36	1.52	16.49	1	090
24065		A	BIOPSY ARM/ELBOW SOFT TISSUE	2.14	0.83	0.10	3.07	1	010
24066		A	BIOPSY ARM/ELBOW SOFT TISSUE	5.23	2.86	0.43	8.52	1	090
24075		A	REMOVE ARM/ELBOW LESION	3.99	2.09	0.36	6.44	1	090
24076		A	REMOVE ARM/ELBOW LESION	6.34	3.88	0.71	10.93	1	090
24077		A	REMOVE TUMOR OF ARM/ELBOW	11.78	10.32	1.96	24.06	1	090
24100		A	BIOPSY ELBOW JOINT LINING	4.92	4.46	0.73	10.11	1	090
24101		A	EXPLORE/TREAT ELBOW JOINT	6.15	9.02	1.49	16.66	1	090
24102		A	REMOVE ELBOW JOINT LINING	7.97	11.72	1.90	21.59	1	090
24105		A	REMOVAL OF ELBOW BURSA	3.62	3.97	0.67	8.26	1	090
24110		A	REMOVE HUMERUS LESION	7.46	8.11	1.29	16.86	1	090
24115		A	REMOVE/GRAFT BONE LESION	9.36	8.10	1.40	18.86	1	090
24116		A	REMOVE/GRAFT BONE LESION	11.73	10.25	1.55	23.53	1	090
24120		A	REMOVE ELBOW LESION	6.70	6.35	1.03	14.08	1	090
24125		A	REMOVE/GRAFT BONE LESION	7.80	6.10	0.65	14.55	1	090
24126		A	REMOVE/GRAFT BONE LESION	8.18	7.80	1.28	17.26	1	090
24130		A	REMOVAL OF HEAD OF RADIUS	6.28	7.08	1.13	14.49	1	090
24134		A	REMOVAL OF ARM BONE LESION	9.46	9.17	1.31	19.94	1	090
24136		A	REMOVE RADIUS BONE LESION	7.73	9.26	0.97	17.96	1	090
24138		A	REMOVE ELBOW BONE LESION	7.76	6.74	1.11	15.61	1	090
24140		A	PARTIAL REMOVAL OF ARM BONE	9.02	9.25	1.53	19.80	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
24145		A	PARTIAL REMOVAL OF RADIUS	7.50	6.72	1.08	15.30	1	090
24147		A	PARTIAL REMOVAL OF ELBOW	7.38	6.96	1.13	15.47	1	090
24150		A	EXTENSIVE HUMERUS SURGERY	13.10	14.84	2.36	30.30	1	090
24151		A	EXTENSIVE HUMERUS SURGERY	15.44	14.57	2.22	32.23	1	090
24152		A	EXTENSIVE RADIUS SURGERY	10.03	7.17	1.22	18.42	1	090
24153		A	EXTENSIVE RADIUS SURGERY	11.55	11.01	1.80	24.36	1	090
24155		A	REMOVAL OF ELBOW JOINT	11.71	11.33	1.81	24.85	1	090
24160		A	REMOVE ELBOW JOINT IMPLANT	7.83	5.09	0.84	13.76	1	090
24164		A	REMOVE RADIUS HEAD IMPLANT	6.10	5.82	0.95	12.87	1	090
24200		A	REMOVAL OF ARM FOREIGN BODY	1.80	0.60	0.06	2.46	1	010
24201		A	REMOVAL OF ARM FOREIGN BODY	4.54	3.22	0.52	8.28	1	090
24220		A	INJECTION FOR ELBOW X-RAY	1.38	0.55	0.05	1.98	2	ZZZ
24301		A	MUSCLE/TENDON TRANSFER	10.31	8.33	1.30	19.94	1	090
24305		A	ARM TENDON LENGTHENING	7.55	3.24	0.30	11.09	1	090
24310		A	REVISION OF ARM TENDON	6.03	3.11	0.51	9.65	1	090
24320		A	REPAIR OF ARM TENDON	10.54	9.69	1.36	21.59	1	090
24330		A	REVISION OF ARM MUSCLES	9.67	9.22	1.51	20.40	1	090
24331		A	REVISION OF ARM MUSCLES	10.64	10.14	1.66	22.44	1	090
24340		A	REPAIR OF RUPTURED TENDON	7.98	7.38	1.18	16.54	1	090
24342		A	REPAIR OF RUPTURED TENDON	10.67	10.94	1.85	23.46	1	090
24350		A	REPAIR OF TENNIS ELBOW	5.33	4.46	0.73	10.52	1	090
24351		A	REPAIR OF TENNIS ELBOW	6.04	5.69	0.94	12.67	1	090
24352		A	REPAIR OF TENNIS ELBOW	6.47	6.00	0.98	13.45	1	090
24354		A	REPAIR OF TENNIS ELBOW	6.52	5.90	0.99	13.41	1	090
24356		A	REVISION OF TENNIS ELBOW	6.74	7.67	1.24	15.65	1	090
24360		A	RECONSTRUCT ELBOW JOINT	12.39	16.13	2.60	31.12	1	090
24361		A	RECONSTRUCT ELBOW JOINT	14.23	13.84	2.11	30.18	1	090
24362		A	RECONSTRUCT ELBOW JOINT	15.18	13.86	0.84	29.88	1	090
24363		A	REPLACE ELBOW JOINT	18.62	27.17	4.35	50.14	1	090
24365		A	RECONSTRUCT HEAD OF RADIUS	8.36	7.92	1.25	17.53	1	090
24366		A	RECONSTRUCT HEAD OF RADIUS	9.14	11.64	1.89	22.67	1	090
24400		A	REVISION OF HUMERUS	11.12	8.88	1.45	21.45	1	090
24410		A	REVISION OF HUMERUS	15.05	14.80	2.17	32.02	1	090
24420		A	REVISION OF HUMERUS	13.59	12.96	2.12	28.67	1	090
24430		A	REPAIR OF HUMERUS	12.92	15.45	2.47	30.84	1	090
24435		A	REPAIR HUMERUS WITH GRAFT	12.85	18.67	2.99	34.51	1	090
24470		A	REVISION OF ELBOW JOINT	8.76	8.35	1.37	18.48	1	090
24495		A	DECOMPRESSION OF FOREARM	7.99	6.06	1.15	15.20	1	090
24498		A	REINFORCE HUMERUS	11.91	10.93	1.71	24.55	1	090
24500		A	TREAT HUMERUS FRACTURE	3.17	2.67	0.37	6.21	2	090
24505		A	TREAT HUMERUS FRACTURE	5.08	4.74	0.75	10.57	1	090
24506		A	TREAT HUMERUS FRACTURE	7.97	8.24	1.33	17.54	1	090
24510		A	REPAIR HUMERUS FRACTURE	8.32	5.87	0.93	15.12	1	090
24515		A	REPAIR HUMERUS FRACTURE	11.51	10.17	1.63	23.31	1	090
24530		A	TREAT HUMERUS FRACTURE	3.48	2.88	0.44	6.80	2	090
24531		A	TREAT HUMERUS FRACTURE	6.78	6.34	0.88	14.00	1	090
24535		A	TREAT HUMERUS FRACTURE	6.86	5.10	0.82	12.78	1	090
24536		A	TREAT HUMERUS FRACTURE	8.44	8.05	1.32	17.81	1	090
24538		A	TREAT HUMERUS FRACTURE	9.33	8.41	1.33	19.07	1	090
24540		A	TREAT HUMERUS FRACTURE	7.49	6.49	1.12	15.10	1	090
24542		A	TREAT HUMERUS FRACTURE	9.93	9.47	1.55	20.95	1	090
24545		A	REPAIR HUMERUS FRACTURE	12.81	10.50	1.68	24.99	1	090
24560		A	TREAT HUMERUS FRACTURE	2.76	2.27	0.31	5.34	2	090
24565		A	TREAT HUMERUS FRACTURE	5.50	3.64	0.58	9.72	1	090
24570		A	REPAIR HUMERUS FRACTURE	6.35	6.05	0.99	13.39	1	090
24575		A	REPAIR HUMERUS FRACTURE	10.44	8.21	1.31	19.96	1	090
24576		A	TREAT HUMERUS FRACTURE	2.81	2.27	0.34	5.42	2	090
24577		A	TREAT HUMERUS FRACTURE	5.74	4.21	0.65	10.60	1	090
24578		A	REPAIR HUMERUS FRACTURE	7.83	7.47	1.22	16.52	1	090
24579		A	REPAIR HUMERUS FRACTURE	11.43	8.82	1.42	21.67	1	090
24580		A	TREAT ELBOW FRACTURE	5.99	3.92	0.57	10.48	1	090
24581		A	TREAT ELBOW FRACTURE	8.06	5.90	0.93	14.89	1	090
24583		A	REPAIR ELBOW FRACTURE	9.38	8.71	1.41	19.50	1	090
24585		A	REPAIR ELBOW FRACTURE	13.27	13.13	2.09	28.49	1	090
24586		A	REPAIR ELBOW FRACTURE	15.14	15.51	2.49	33.14	1	090
24587		A	REPAIR ELBOW FRACTURE	15.03	14.45	2.28	31.76	1	090
24588		A	REPAIR ELBOW FRACTURE	15.83	15.09	2.47	33.39	1	090
24600		A	TREAT ELBOW DISLOCATION	4.30	2.06	0.27	6.63	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
24605		A	TREAT ELBOW DISLOCATION	5.36	2.42	0.38	8.16	1	090
24610		A	REPAIR ELBOW DISLOCATION	7.65	6.95	1.13	15.73	1	090
24615		A	REPAIR ELBOW DISLOCATION	9.24	9.78	1.56	20.58	1	090
24620		A	TREAT ELBOW FRACTURE	6.97	3.98	0.61	11.56	1	090
24625		A	REPAIR ELBOW FRACTURE	9.22	8.93	1.36	19.51	1	090
24635		A	REPAIR ELBOW FRACTURE	13.09	11.65	1.87	26.61	1	090
24640		A	TREAT ELBOW DISLOCATION	1.21	1.06	0.08	2.35	2	010
24650		A	TREAT RADIUS FRACTURE	2.12	2.38	0.34	4.84	2	090
24655		A	TREAT RADIUS FRACTURE	4.40	3.17	0.48	8.05	1	090
24660		A	REPAIR RADIUS FRACTURE	5.67	5.43	0.82	11.92	1	090
24665		A	REPAIR RADIUS FRACTURE	8.11	7.52	1.20	16.83	1	090
24666		A	REPAIR RADIUS FRACTURE	9.35	10.82	1.69	21.86	1	090
24670		A	TREATMENT OF ULNA FRACTURE	2.52	2.06	0.28	4.86	2	090
24675		A	TREATMENT OF ULNA FRACTURE	4.76	3.70	0.58	9.04	1	090
24680		A	REPAIR ULNA FRACTURE	6.88	5.20	0.85	12.93	1	090
24685		A	REPAIR ULNA FRACTURE	8.78	8.85	1.41	19.04	1	090
24800		A	FUSION OF ELBOW JOINT	11.33	11.16	1.64	24.13	1	090
24802		A	FUSION/GRAFT OF ELBOW JOINT	13.47	12.84	2.10	28.41	1	090
24900		A	AMPUTATION OF UPPER ARM	9.24	8.10	1.47	18.81	1	090
24920		A	AMPUTATION OF UPPER ARM	9.16	7.15	1.26	17.57	1	090
24925		A	AMPUTATION FOLLOW-UP SURGERY	6.96	6.60	0.79	14.35	1	090
24930		A	AMPUTATION FOLLOW-UP SURGERY	9.91	8.60	1.23	19.74	1	090
24931		A	AMPUTATE UPPER ARM & IMPLANT	12.34	11.77	1.93	26.04	1	090
24935		A	REVISION OF AMPUTATION	15.14	14.43	2.36	31.93	1	090
24940		C	REVISION OF UPPER ARM	0.00	0.00	0.00	0.00		090
24999		C	UPPER ARM/ELBOW SURGERY	0.00	0.00	0.00	0.00		YYY
25000		A	INCISION OF TENDON SHEATH	3.33	4.14	0.66	8.13	1	090
25005		A	INCISION OF TENDON SHEATH	3.68	4.22	0.68	8.58	1	090
25020		A	DECOMPRESSION OF FOREARM	5.84	4.59	0.81	11.24	1	090
25023		A	DECOMPRESSION OF FOREARM	12.44	9.69	1.69	23.82	1	090
25028		A	DRAINAGE OF FOREARM LESION	5.13	2.17	0.37	7.67	1	090
25031		A	DRAINAGE OF FOREARM BURSA	4.10	3.90	0.49	8.49	1	090
25035		A	TREAT FOREARM BONE LESION	7.20	6.63	1.06	14.89	1	090
25040		A	EXPLORE/TREAT WRIST JOINT	6.96	6.00	0.95	13.91	1	090
25065		A	BIOPSY FOREARM SOFT TISSUES	2.52	0.79	0.09	3.40	1	010
25066		A	BIOPSY FOREARM SOFT TISSUES	4.07	1.63	0.23	5.93	1	090
25075		A	REMOVAL OF FOREARM LESION	3.81	2.30	0.38	6.49	1	090
25076		A	REMOVAL OF FOREARM LESION	5.02	3.97	0.71	9.70	1	090
25077		A	REMOVE TUMOR, FOREARM/WRIST	9.74	8.93	1.76	20.43	1	090
25085		A	INCISION OF WRIST CAPSULE	5.41	4.87	0.75	11.03	1	090
25100		A	BIOPSY OF WRIST JOINT	3.86	5.13	0.83	9.82	1	090
25101		A	EXPLORE/TREAT WRIST JOINT	4.67	5.90	1.03	11.60	1	090
25105		A	REMOVE WRIST JOINT LINING	5.85	7.56	1.26	14.67	1	090
25107		A	REMOVE WRIST JOINT CARTILAGE	6.21	5.56	0.94	12.71	1	090
25110		A	REMOVE WRIST TENDON LESION	3.99	2.95	0.49	7.43	1	090
25111		A	REMOVE WRIST TENDON LESION	3.42	3.39	0.59	7.40	1	090
25112		A	REREMOVE WRIST TENDON LESION	4.62	3.92	0.70	9.24	1	090
25115		A	REMOVE WRIST/FOREARM LESION	6.59	7.53	1.30	15.42	1	090
25116		A	REMOVE WRIST/FOREARM LESION	6.79	8.61	1.46	16.86	1	090
25118		A	EXCISE WRIST TENDON SHEATH	4.33	6.46	1.07	11.86	1	090
25119		A	PARTIAL REMOVAL OF ULNA	5.95	8.40	1.39	15.74	1	090
25120		A	REMOVAL OF FOREARM LESION	6.01	6.88	1.20	14.09	1	090
25125		A	REMOVE/GRAFT FOREARM LESION	7.44	7.21	1.09	15.74	1	090
25126		A	REMOVE/GRAFT FOREARM LESION	7.51	7.17	1.17	15.85	1	090
25130		A	REMOVAL OF WRIST LESION	5.36	4.44	0.71	10.51	1	090
25135		A	REMOVE & GRAFT WRIST LESION	6.93	5.75	1.02	13.70	1	090
25136		A	REMOVE & GRAFT WRIST LESION	5.99	4.99	0.89	11.87	1	090
25145		A	REMOVE FOREARM BONE LESION	6.30	6.27	0.79	13.36	1	090
25150		A	PARTIAL REMOVAL OF ULNA	6.91	6.40	1.04	14.35	1	090
25151		A	PARTIAL REMOVAL OF RADIUS	7.23	6.06	1.07	14.36	1	090
25170		A	EXTENSIVE FOREARM SURGERY	11.02	10.32	1.59	22.93	1	090
25210		A	REMOVAL OF WRIST BONE	5.84	5.13	0.84	11.81	1	090
25215		A	REMOVAL OF WRIST BONES	7.80	9.15	1.50	18.45	1	090
25230		A	PARTIAL REMOVAL OF RADIUS	5.11	5.86	0.89	11.86	1	090
25240		A	PARTIAL REMOVAL OF ULNA	5.17	5.59	0.91	11.67	1	090
25246		A	INJECTION FOR WRIST X-RAY	1.53	0.54	0.05	2.12	2	ZZZ
25248		A	REMOVE FOREARM FOREIGN BODY	5.24	2.29	0.38	7.91	1	090
25250		A	REMOVAL OF WRIST PROSTHESIS	6.64	5.92	0.96	13.52	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUS	PRACTICE EXPENSE RVUS	MAL- PRACTICE RVUS	TOTAL RVUS	SOURCE OF WORK RVUS	GLOBAL FEE PERIOD
25251		A	REMOVAL OF WRIST PROSTHEIS	9.57	8.69	1.47	19.73	1	090
25260		A	REPAIR FOREARM TENDON/MUSCLE	7.72	4.86	0.82	13.40	1	090
25263		A	REPAIR FOREARM TENDON/MUSCLE	7.77	6.08	1.08	14.93	1	090
25265		A	REPAIR FOREARM TENDON/MUSCLE	10.06	8.36	1.49	19.91	1	090
25270		A	REPAIR FOREARM TENDON/MUSCLE	6.02	3.54	0.59	10.15	1	090
25272		A	REPAIR FOREARM TENDON/MUSCLE	7.12	3.63	0.58	11.33	1	090
25274		A	REPAIR FOREARM TENDON/MUSCLE	8.89	6.97	1.18	17.04	1	090
25280		A	REVISE WRIST/FOREARM TENDON	7.19	4.45	0.73	12.37	1	090
25290		A	INCISE WRIST/FOREARM TENDON	5.31	2.60	0.43	8.34	1	090
25295		A	RELEASE WRIST/FOREARM TENDON	6.59	3.21	0.56	10.36	1	090
25300		A	FUSION OF TENDONS AT WRIST	8.91	7.76	1.26	17.93	1	090
25301		A	FUSION OF TENDONS AT WRIST	8.53	7.14	1.24	16.91	1	090
25310		A	TRANSPLANT FOREARM TENDON	8.10	7.53	1.23	16.86	1	090
25312		A	TRANSPLANT FOREARM TENDON	9.57	8.06	1.36	18.99	1	090
25315		A	REVISE PALSY HAND TENDON(S)	9.89	8.47	1.42	19.78	1	090
25316		A	REVISE PALSY HAND TENDON(S)	11.96	10.91	1.84	24.71	1	090
25317		A	REVISE HAND CONTRACTURE	10.41	8.96	1.35	20.72	1	090
25318		A	REVISE HAND CONTRACTURE	13.10	12.49	2.04	27.63	1	090
25320		A	REPAIR/REVISE WRIST JOINT	9.64	9.06	1.53	20.23	1	090
25330		A	REVISE WRIST JOINT	11.43	9.72	1.58	22.73	1	090
25331		A	REVISE WRIST JOINT	13.28	15.45	2.53	31.26	1	090
25332		A	REVISE WRIST JOINT	11.41	10.51	1.70	23.62	1	090
25335		A	REALIGNMENT OF HAND	12.75	12.02	1.65	26.42	1	090
25350		A	REVISION OF RADIUS	8.67	8.01	1.33	18.01	1	090
25355		A	REVISION OF RADIUS	10.07	9.61	1.57	21.25	1	090
25360		A	REVISION OF ULNA	8.30	6.76	1.04	16.10	1	090
25365		A	REVISE RADIUS & ULNA	12.25	10.86	1.66	24.77	1	090
25370		A	REVISE RADIUS OR ULNA	13.00	12.40	2.03	27.43	1	090
25375		A	REVISE RADIUS & ULNA	12.93	14.10	0.92	27.95	1	090
25390		A	SHORTEN RADIUS/ULNA	10.38	9.30	1.58	21.26	1	090
25391		A	LENGTHEN RADIUS/ULNA	13.43	11.86	2.04	27.33	1	090
25392		A	SHORTEN RADIUS & ULNA	13.75	13.11	2.15	29.01	1	090
25393		A	LENGTHEN RADIUS & ULNA	15.71	14.98	2.45	33.14	1	090
25400		A	REPAIR RADIUS OR ULNA	10.85	11.36	1.84	24.05	1	090
25405		A	REPAIR/GRAFT RADIUS OR ULNA	14.21	13.09	2.13	29.43	1	090
25415		A	REPAIR RADIUS & ULNA	13.32	12.04	2.03	27.39	1	090
25420		A	REPAIR/GRAFT RADIUS & ULNA	16.16	15.55	2.44	34.15	1	090
25425		A	REPAIR/GRAFT RADIUS OR ULNA	13.12	12.66	1.96	27.74	1	090
25426		A	REPAIR/GRAFT RADIUS & ULNA	15.73	12.35	2.24	30.32	1	090
25440		A	REPAIR/GRAFT WRIST BONE	10.48	9.54	1.58	21.60	1	090
25441		A	RECONSTRUCT WRIST JOINT	12.92	11.97	2.00	26.89	1	090
25442		A	RECONSTRUCT WRIST JOINT	10.89	7.44	1.29	19.62	1	090
25443		A	RECONSTRUCT WRIST JOINT	10.41	9.87	1.60	21.88	1	090
25444		A	RECONSTRUCT WRIST JOINT	11.21	10.69	1.75	23.65	1	090
25445		A	RECONSTRUCT WRIST JOINT	9.76	10.92	1.81	22.49	1	090
25446		A	WRIST REPLACEMENT	16.36	21.84	3.68	41.88	1	090
25447		A	REPAIR WRIST JOINT(S)	11.97	10.07	1.62	23.66	1	090
25449		A	REMOVE WRIST JOINT IMPLANT	14.51	8.26	1.22	23.99	1	090
25450		A	REVISION OF WRIST JOINT	8.08	7.70	1.26	17.04	1	090
25455		A	REVISION OF WRIST JOINT	9.64	9.19	1.50	20.33	1	090
25490		A	REINFORCE RADIUS	9.61	9.16	1.50	20.27	1	090
25491		A	REINFORCE ULNA	10.06	9.59	1.57	21.22	1	090
25492		A	REINFORCE RADIUS AND ULNA	12.38	11.80	1.93	26.11	1	090
25500		A	TREAT FRACTURE OF RADIUS	2.43	2.46	0.30	5.19	2	090
25505		A	TREAT FRACTURE OF RADIUS	5.24	3.76	0.55	9.55	1	090
25510		A	REPAIR FRACTURE OF RADIUS	6.33	5.96	0.89	13.18	1	090
25515		A	REPAIR FRACTURE OF RADIUS	9.10	8.03	1.29	18.42	1	090
25530		A	TREAT FRACTURE OF ULNA	2.05	2.57	0.36	4.98	2	090
25535		A	TREAT FRACTURE OF ULNA	5.17	3.76	0.58	9.51	1	090
25540		A	REPAIR FRACTURE OF ULNA	6.02	5.74	0.86	12.62	1	090
25545		A	REPAIR FRACTURE OF ULNA	8.79	7.98	1.27	18.04	1	090
25560		A	TREAT FRACTURE RADIUS & ULNA	2.42	2.40	0.28	5.10	2	090
25565		A	TREAT FRACTURE RADIUS & ULNA	5.58	4.91	0.74	11.23	1	090
25570		A	REPAIR FRACTURE RADIUS/ULNA	7.48	5.91	0.88	14.27	1	090
25575		A	REPAIR FRACTURE RADIUS/ULNA	9.81	11.27	1.82	22.90	1	090
25600		A	TREAT FRACTURE RADIUS/ULNA	2.61	2.99	0.44	6.04	2	090
25605		A	TREAT FRACTURE RADIUS/ULNA	5.71	4.16	0.65	10.52	1	090
25610		A	REPAIR FRACTURE RADIUS/ULNA	5.49	5.22	0.83	11.54	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPs*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
25611		A	REPAIR FRACTURE RADIUS/ULNA	7.49	6.34	1.02	14.85	1	090
25615		A	REPAIR FRACTURE RADIUS/ULNA	6.71	5.35	0.82	12.88	1	090
25620		A	REPAIR FRACTURE RADIUS/ULNA	8.59	7.51	1.20	17.30	1	090
25622		A	TREAT WRIST BONE FRACTURE	2.56	2.41	0.34	5.31	2	090
25624		A	TREAT WRIST BONE FRACTURE	4.52	3.87	0.61	9.00	1	090
25626		A	REPAIR WRIST BONE FRACTURE	6.10	5.35	0.87	12.32	1	090
25628		A	REPAIR WRIST BONE FRACTURE	8.23	7.52	1.22	16.97	1	090
25630		A	TREAT WRIST BONE FRACTURE	2.88	2.30	0.31	5.49	2	090
25635		A	TREAT WRIST BONE FRACTURE	4.39	3.54	0.54	8.47	1	090
25640		A	REPAIR WRIST BONE FRACTURE	5.82	5.60	0.88	12.30	1	090
25645		A	REPAIR WRIST BONE FRACTURE	7.22	7.04	1.00	15.26	1	090
25650		A	REPAIR WRIST BONE FRACTURE	3.02	2.81	0.37	6.20	1	090
25660		A	TREAT WRIST DISLOCATION	4.77	1.91	0.27	6.95	1	090
25665		A	REPAIR WRIST DISLOCATION	6.05	6.02	0.75	12.82	1	090
25670		A	REPAIR WRIST DISLOCATION	7.92	7.46	1.17	16.55	1	090
25675		A	TREAT WRIST DISLOCATION	4.68	2.41	0.35	7.44	1	090
25676		A	REPAIR WRIST DISLOCATION	7.95	7.71	1.16	16.82	1	090
25680		A	TREAT WRIST FRACTURE	5.94	5.63	0.85	12.42	1	090
25685		A	REPAIR WRIST FRACTURE	9.72	9.27	1.52	20.51	1	090
25690		A	TREAT WRIST DISLOCATION	5.44	5.14	0.77	11.35	1	090
25695		A	REPAIR WRIST DISLOCATION	8.37	7.42	1.23	17.02	1	090
25800		A	FUSION OF WRIST JOINT	9.70	11.53	1.89	23.12	1	090
25805		A	FUSION/GRAFT OF WRIST JOINT	11.14	13.54	2.20	26.88	1	090
25810		A	FUSION/GRAFT OF WRIST JOINT	10.32	13.34	2.17	25.83	1	090
25820		A	FUSION OF HAND BONES	7.53	6.52	1.10	15.15	1	090
25825		A	FUSION HAND BONES WITH GRAFT	9.06	12.74	2.10	23.90	1	090
25900		A	AMPUTATION OF FOREARM	8.59	7.46	1.38	17.43	1	090
25905		A	AMPUTATION OF FOREARM	8.85	7.49	1.21	17.55	1	090
25907		A	AMPUTATION FOLLOW-UP SURGERY	7.66	6.05	1.05	14.76	1	090
25909		A	AMPUTATION FOLLOW-UP SURGERY	8.82	5.84	1.11	15.77	1	090
25915		C	AMPUTATION OF FOREARM	0.00	0.00	0.00	0.00		090
25920		A	AMPUTATE HAND AT WRIST	8.53	6.46	1.19	16.18	1	090
25922		A	AMPUTATE HAND AT WRIST	7.33	5.84	1.07	14.24	1	090
25924		A	AMPUTATION FOLLOW-UP SURGERY	8.29	7.90	1.29	17.48	1	090
25927		A	AMPUTATION OF HAND	8.71	6.62	1.29	16.62	1	090
25929		A	AMPUTATION FOLLOW-UP SURGERY	7.51	4.99	1.01	13.51	1	090
25931		A	AMPUTATION FOLLOW-UP SURGERY	7.75	4.78	0.95	13.48	1	090
25999		C	FOREARM OR WRIST SURGERY	0.00	0.00	0.00	0.00		YYY
26010		A	DRAINAGE OF FINGER ABSCESS	1.57	0.51	0.05	2.13	1	010
26011		A	DRAINAGE OF FINGER ABSCESS	2.25	1.63	0.25	4.13	1	010
26020		A	DRAIN HAND TENDON SHEATH	4.22	3.92	0.67	8.81	1	090
26025		A	DRAINAGE OF PALM BURSA	4.56	4.75	0.80	10.11	1	090
26030		A	DRAINAGE OF PALM BURSA(S)	5.65	6.04	1.03	12.72	1	090
26034		A	TREAT HAND BONE LESION	5.88	4.46	0.75	11.09	1	090
26035		A	DECOMPRESS FINGERS/HAND	8.83	5.45	0.91	15.19	1	090
26037		A	DECOMPRESS FINGERS/HAND	7.04	6.71	1.10	14.85	1	090
26040		A	RELEASE PALM CONTRACTURE	3.25	3.01	0.52	6.78	1	090
26045		A	RELEASE PALM CONTRACTURE	5.55	5.08	0.85	11.48	1	090
26055		A	INCISE FINGER TENDON SHEATH	2.69	3.62	0.60	6.91	1	090
26060		A	INCISION OF FINGER TENDON	2.86	1.18	0.17	4.21	1	090
26070		A	EXPLORE/TREAT HAND JOINT	3.52	2.91	0.44	6.87	1	090
26075		A	EXPLORE/TREAT FINGER JOINT	3.63	3.98	0.66	8.27	1	090
26080		A	EXPLORE/TREAT FINGER JOINT	3.98	3.30	0.55	7.83	1	090
26100		A	BIOPSY HAND JOINT LINING	3.73	3.15	0.48	7.36	1	090
26105		A	BIOPSY FINGER JOINT LINING	3.78	4.40	0.71	8.89	1	090
26110		A	BIOPSY FINGER JOINT LINING	3.59	3.09	0.53	7.21	1	090
26115		A	REMOVAL OF HAND LESION	3.88	2.12	0.35	6.35	1	090
26116		A	REMOVAL OF HAND LESION	5.47	3.91	0.66	10.04	1	090
26117		A	REMOVE TUMOR, HAND/FINGER	8.68	5.35	0.96	14.99	1	090
26121		A	RELEASE PALM CONTRACTURE	7.74	9.95	1.70	19.39	1	090
26123		A	RELEASE PALM CONTRACTURE	9.11	9.59	1.61	20.31	1	090
26125		A	RELEASE PALM CONTRACTURE	9.71	5.50	0.94	16.15	1	090
26130		A	REMOVE WRIST JOINT LINING	5.41	5.29	0.91	11.61	1	090
26135		A	REVISE FINGER JOINT, EACH	7.03	5.11	0.86	13.00	1	090
26140		A	REVISE FINGER JOINT, EACH	6.20	4.64	0.79	11.63	1	090
26145		A	TENDON EXCISION, PALM/FINGER	6.36	4.96	0.84	12.16	1	090
26160		A	REMOVE TENDON SHEATH LESION	3.16	2.45	0.42	6.03	1	090
26170		A	REMOVAL OF PALM TENDON, EACH	4.87	2.98	0.47	8.32	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
26180		A	REMOVAL OF FINGER TENDON	5.28	4.22	0.75	10.25	1	090
26200		A	REMOVE HAND BONE LESION	5.53	4.72	0.76	11.01	1	090
26205		A	REMOVE/GRAFT BONE LESION	7.63	6.75	1.08	15.46	1	090
26210		A	REMOVAL OF FINGER LESION	5.25	4.10	0.68	10.03	1	090
26215		A	REMOVE/GRAFT FINGER LESION	7.18	5.84	0.99	14.01	1	090
26230		A	PARTIAL REMOVAL OF HAND BONE	6.29	4.50	0.73	11.52	1	090
26235		A	PARTIAL REMOVAL, FINGER BONE	6.13	4.40	0.75	11.28	1	090
26236		A	PARTIAL REMOVAL, FINGER BONE	5.23	4.06	0.70	9.99	1	090
26250		A	EXTENSIVE HAND SURGERY	7.65	6.33	1.12	15.10	1	090
26255		A	EXTENSIVE HAND SURGERY	12.29	9.42	1.63	23.34	1	090
26260		A	EXTENSIVE FINGER SURGERY	7.11	6.04	1.02	14.17	1	090
26261		A	EXTENSIVE FINGER SURGERY	8.99	8.12	1.38	18.49	1	090
26262		A	PARTIAL REMOVAL OF FINGER	5.70	5.00	0.80	11.50	1	090
26320		A	REMOVAL OF IMPLANT FROM HAND	3.94	3.73	0.61	8.28	1	090
26350		A	REPAIR FINGER/HAND TENDON	6.07	6.05	1.04	13.16	1	090
26352		A	REPAIR/GRAFT HAND TENDON	7.65	6.95	1.15	15.75	1	090
26356		A	REPAIR FINGER/HAND TENDON	7.43	7.60	1.31	16.34	1	090
26357		A	REPAIR FINGER/HAND TENDON	8.60	6.93	1.26	16.79	1	090
26358		A	REPAIR/GRAFT HAND TENDON	9.16	7.80	1.34	18.30	1	090
26370		A	REPAIR FINGER/HAND TENDON	7.07	7.07	1.18	15.32	1	090
26372		A	REPAIR/GRAFT HAND TENDON	8.71	6.74	1.21	16.66	1	090
26373		A	REPAIR FINGER/HAND TENDON	8.09	7.22	1.16	16.47	1	090
26390		A	REVISE HAND/FINGER TENDON	9.21	8.38	1.30	18.89	1	090
26392		A	REPAIR/GRAFT HAND TENDON	10.30	9.07	1.33	20.70	1	090
26410		A	REPAIR HAND TENDON	4.61	3.47	0.55	8.63	1	090
26412		A	REPAIR/GRAFT HAND TENDON	6.23	6.34	1.02	13.59	1	090
26415		A	EXCISION, HAND/FINGER TENDON	8.49	7.12	0.95	16.56	2	090
26416		A	GRAFT HAND OR FINGER TENDON	9.55	9.11	1.49	20.15	2	090
26418		A	REPAIR FINGER TENDON	4.23	3.78	0.63	8.64	1	090
26420		A	REPAIR/GRAFT FINGER TENDON	6.71	5.99	1.01	13.71	1	090
26426		A	REPAIR FINGER/HAND TENDON	6.18	6.65	1.12	13.95	1	090
26428		A	REPAIR/GRAFT FINGER TENDON	7.27	5.79	1.05	14.11	1	090
26432		A	REPAIR FINGER TENDON	4.07	3.31	0.55	7.93	1	090
26433		A	REPAIR FINGER TENDON	4.65	4.15	0.70	9.50	1	090
26434		A	REPAIR/GRAFT FINGER TENDON	6.11	5.23	0.88	12.22	1	090
26437		A	REALIGNMENT OF TENDONS	5.82	4.27	0.72	10.81	1	090
26440		A	RELEASE PALM/FINGER TENDON	5.01	3.76	0.63	9.40	1	090
26442		A	RELEASE PALM & FINGER TENDON	6.43	3.55	0.63	10.61	1	090
26445		A	RELEASE HAND/FINGER TENDON	4.39	3.43	0.58	8.40	1	090
26449		A	RELEASE FOREARM/HAND TENDON	6.74	5.86	1.01	13.61	1	090
26450		A	INCISION OF PALM TENDON	3.73	2.41	0.37	6.51	1	090
26455		A	INCISION OF FINGER TENDON	3.70	2.00	0.34	6.04	1	090
26460		A	INCISE HAND/FINGER TENDON	3.51	1.81	0.31	5.63	1	090
26471		A	FUSION OF FINGER TENDONS	5.84	4.38	0.71	10.93	1	090
26474		A	FUSION OF FINGER TENDONS	5.42	4.86	0.79	11.07	1	090
26476		A	TENDON LENGTHENING	5.28	3.04	0.28	8.60	1	090
26477		A	TENDON SHORTENING	5.25	4.20	0.77	10.22	1	090
26478		A	LENGTHENING OF HAND TENDON	5.91	5.63	0.91	12.45	1	090
26479		A	SHORTENING OF HAND TENDON	5.85	5.58	0.91	12.34	1	090
26480		A	TRANSPLANT HAND TENDON	6.84	6.88	1.16	14.88	1	090
26483		A	TRANSPLANT/GRAFT HAND TENDON	8.29	8.95	1.48	18.72	1	090
26485		A	TRANSPLANT PALM TENDON	7.67	6.85	1.13	15.65	1	090
26489		A	TRANSPLANT/GRAFT PALM TENDON	9.48	3.59	0.55	13.62	1	090
26490		A	REVISE THUMB TENDON	8.42	8.22	1.35	17.99	1	090
26492		A	TENDON TRANSFER WITH GRAFT	9.66	9.23	1.28	20.17	1	090
26494		A	HAND TENDON/MUSCLE TRANSFER	8.49	7.67	1.30	17.46	2	090
26496		A	REVISE THUMB TENDON	9.66	9.21	1.62	20.49	1	090
26497		A	FINGER TENDON TRANSFER	9.64	8.46	1.46	19.56	1	090
26498		A	FINGER TENDON TRANSFER	14.28	12.42	2.15	28.85	1	090
26499		A	REVISION OF FINGER	9.02	8.17	1.32	18.51	2	090
26500		A	HAND TENDON RECONSTRUCTION	5.98	3.68	0.64	10.30	1	090
26502		A	HAND TENDON RECONSTRUCTION	7.10	5.55	1.00	13.65	1	090
26504		A	HAND TENDON RECONSTRUCTION	7.43	7.08	1.16	15.67	2	090
26508		A	RELEASE THUMB CONTRACTURE	5.90	4.38	0.76	11.04	1	090
26510		A	THUMB TENDON TRANSFER	5.31	4.38	0.72	10.41	1	090
26516		A	FUSION OF KNUCKLE JOINT	7.12	4.39	0.71	12.22	1	090
26517		A	FUSION OF KNUCKLE JOINTS	8.78	7.45	1.30	17.53	1	090
26518		A	FUSION OF KNUCKLE JOINTS	8.98	6.86	1.29	17.13	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPs*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
26520		A	RELEASE KNUCKLE CONTRACTURE	5.29	4.72	0.75	10.76	1	090
26525		A	RELEASE FINGER CONTRACTURE	5.32	3.84	0.66	9.82	1	090
26527		A	REVISE WRIST JOINT	8.81	10.30	1.70	20.81	1	090
26530		A	REVISE KNUCKLE JOINT	6.72	5.44	0.89	13.05	1	090
26531		A	REVISE KNUCKLE WITH IMPLANT	7.97	7.01	1.16	16.14	1	090
26535		A	REVISE FINGER JOINT	5.22	5.09	0.62	10.93	1	090
26536		A	REVISE/IMPLANT FINGER JOINT	8.29	7.60	1.26	17.15	1	090
26540		A	REPAIR HAND JOINT	6.36	6.99	1.17	14.52	1	090
26541		A	REPAIR HAND JOINT WITH GRAFT	8.64	9.42	1.55	19.61	1	090
26542		A	REPAIR HAND JOINT WITH GRAFT	6.73	5.98	1.02	13.73	1	090
26545		A	RECONSTRUCT FINGER JOINT	6.85	5.55	0.99	13.39	1	090
26548		A	RECONSTRUCT FINGER JOINT	8.01	6.10	1.05	15.16	1	090
26550		C	CONSTRUCT THUMB REPLACEMENT	0.00	0.00	0.00	0.00		090
26552		C	CONSTRUCT THUMB REPLACEMENT	0.00	0.00	0.00	0.00		090
26555		C	POSITIONAL CHANGE OF FINGER	0.00	0.00	0.00	0.00		090
26557		C	CONSTRUCT FINGER REPLACEMENT	0.00	0.00	0.00	0.00		090
26558		C	ADDED FINGER SURGERY	0.00	0.00	0.00	0.00		090
26559		C	ADDED FINGER SURGERY	0.00	0.00	0.00	0.00		090
26560		A	REPAIR OF WEB FINGER	5.51	4.90	0.70	11.11	1	090
26561		A	REPAIR OF WEB FINGER	11.07	9.37	1.65	22.09	1	090
26562		A	REPAIR OF WEB FINGER	9.72	11.56	0.86	22.14	1	090
26565		A	CORRECT METACARPAL FLAW	6.80	6.13	0.90	13.83	1	090
26567		A	CORRECT FINGER DEFORMITY	6.88	4.52	0.71	12.11	1	090
26568		A	LENGTHEN METACARPAL/FINGER	9.13	8.90	1.11	19.14	1	090
26580		C	REPAIR HAND DEFORMITY	0.00	0.00	0.00	0.00		090
26585		C	REPAIR FINGER DEFORMITY	0.00	0.00	0.00	0.00		090
26587		C	RECONSTRUCT EXTRA FINGER	0.00	0.00	0.00	0.00		090
26590		C	REPAIR FINGER DEFORMITY	0.00	0.00	0.00	0.00		090
26591		A	REPAIR MUSCLES OF HAND	3.05	2.42	0.41	5.88	1	090
26593		A	RELEASE MUSCLES OF HAND	5.15	4.34	0.74	10.23	1	090
26596		A	EXCISION CONSTRICTING TISSUE	9.11	8.68	1.42	19.21	2	090
26597		A	RELEASE OF SCAR CONTRACTURE	9.86	8.15	1.40	19.41	2	090
26600		A	TREAT METACARPAL FRACTURE	1.90	1.63	0.23	3.76	2	090
26605		A	TREAT METACARPAL FRACTURE	2.82	2.42	0.37	5.61	1	090
26607		A	TREAT METACARPAL FRACTURE	5.40	3.74	0.61	9.75	1	090
26610		A	REPAIR METACARPAL FRACTURE	4.22	1.79	0.26	6.27	1	090
26615		A	REPAIR METACARPAL FRACTURE	5.46	5.12	0.84	11.42	1	090
26641		A	TREAT THUMB DISLOCATION	3.94	1.16	0.14	5.24	1	090
26645		A	TREAT THUMB FRACTURE	4.46	2.31	0.34	7.11	1	090
26650		A	REPAIR THUMB FRACTURE	5.78	4.22	0.68	10.68	1	090
26655		A	REPAIR THUMB FRACTURE	5.75	5.21	0.83	11.79	1	090
26660		A	REPAIR THUMB FRACTURE	6.99	6.83	0.89	14.71	1	090
26665		A	REPAIR THUMB FRACTURE	7.53	6.74	1.14	15.41	1	090
26670		A	TREAT HAND DISLOCATION	3.73	1.01	0.10	4.84	1	090
26675		A	TREAT HAND DISLOCATION	4.68	4.58	0.64	9.90	1	090
26676		A	PIN HAND DISLOCATION	5.58	5.11	0.71	11.40	1	090
26680		A	REPAIR HAND DISLOCATION	5.49	5.61	0.68	11.78	1	090
26685		A	REPAIR HAND DISLOCATION	6.89	6.07	0.96	13.92	1	090
26686		A	REPAIR HAND DISLOCATION	7.88	6.64	1.09	15.61	1	090
26700		A	TREAT KNUCKLE DISLOCATION	3.73	0.93	0.10	4.76	1	090
26705		A	TREAT KNUCKLE DISLOCATION	4.20	1.87	0.28	6.35	1	090
26706		A	PIN KNUCKLE DISLOCATION	5.18	4.93	0.79	10.90	1	090
26710		A	REPAIR KNUCKLE DISLOCATION	4.91	4.21	0.61	9.73	1	090
26715		A	REPAIR KNUCKLE DISLOCATION	5.77	4.35	0.70	10.82	1	090
26720		A	TREAT FINGER FRACTURE, EACH	1.65	1.15	0.15	2.95	2	090
26725		A	TREAT FINGER FRACTURE, EACH	3.35	1.63	0.24	5.22	1	090
26727		A	TREAT FINGER FRACTURE, EACH	5.18	2.58	0.39	8.15	1	090
26730		A	REPAIR FINGER FRACTURE, EACH	4.67	2.16	0.31	7.14	1	090
26735		A	REPAIR FINGER FRACTURE, EACH	6.03	3.93	0.65	10.61	1	090
26740		A	TREAT FINGER FRACTURE, EACH	1.90	1.22	0.16	3.28	2	090
26742		A	TREAT FINGER FRACTURE, EACH	3.90	2.09	0.33	6.32	1	090
26744		A	REPAIR FINGER FRACTURE, EACH	4.88	3.04	0.50	8.42	1	090
26746		A	REPAIR FINGER FRACTURE, EACH	5.84	5.00	0.84	11.68	1	090
26750		A	TREAT FINGER FRACTURE, EACH	1.69	0.87	0.10	2.66	2	090
26755		A	TREAT FINGER FRACTURE, EACH	3.13	1.13	0.15	4.41	1	090
26756		A	PIN FINGER FRACTURE, EACH	4.42	2.01	0.34	6.77	1	090
26760		A	REPAIR FINGER FRACTURE, EACH	3.68	1.85	0.26	5.79	1	090
26765		A	REPAIR FINGER FRACTURE, EACH	4.25	2.81	0.47	7.53	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
26770		A	TREAT FINGER DISLOCATION	3.04	0.80	0.08	3.92	1	090
26775		A	TREAT FINGER DISLOCATION	3.70	1.19	0.17	5.06	1	090
26776		A	PIN FINGER DISLOCATION	4.84	2.19	0.36	7.39	1	090
26780		A	REPAIR FINGER DISLOCATION	4.28	2.01	0.30	6.59	1	090
26785		A	REPAIR FINGER DISLOCATION	4.30	3.13	0.51	7.94	1	090
26820		A	THUMB FUSION WITH GRAFT	8.26	7.01	1.10	16.37	1	090
26841		A	FUSION OF THUMB	7.16	6.50	1.05	14.71	1	090
26842		A	THUMB FUSION WITH GRAFT	8.17	9.04	1.45	18.66	1	090
26843		A	FUSION OF HAND JOINT	7.60	6.71	1.15	15.46	1	090
26844		A	FUSION/GRAFT OF HAND JOINT	8.68	7.75	1.25	17.68	1	090
26850		A	FUSION OF KNUCKLE	6.92	4.88	0.80	12.60	1	090
26852		A	FUSION OF KNUCKLE WITH GRAFT	8.40	6.03	1.05	15.48	1	090
26860		A	FUSION OF FINGER JOINT	4.73	4.54	0.72	9.99	1	090
26861		A	FUSION OF FINGER JOINT, ADDED	1.83	2.81	0.45	5.09	1	ZZZ
26862		A	FUSION/GRAFT OF FINGER JOINT	7.44	5.44	0.90	13.78	1	090
26863		A	FUSE/GRAFT ADDED JOINT	4.10	3.55	0.61	8.26	1	ZZZ
26910		A	AMPUTATE METACARPAL BONE	7.57	5.44	0.98	13.99	1	090
26951		A	AMPUTATION OF FINGER/THUMB	4.65	3.02	0.52	8.19	1	090
26952		A	AMPUTATION OF FINGER/THUMB	6.35	4.21	0.73	11.29	1	090
26989		C	HAND/FINGER SURGERY	0.00	0.00	0.00	0.00		YYY
26990		A	DRAINAGE OF PELVIS LESION	7.13	3.26	0.55	10.94	1	090
26991		A	DRAINAGE OF PELVIS BURSA	6.38	1.90	0.30	8.58	1	090
26992		A	DRAINAGE OF BONE LESION	14.73	6.72	1.10	22.55	1	090
27000		A	INCISION OF HIP TENDON	5.55	1.94	0.25	7.74	1	090
27001		A	INCISION OF HIP TENDON	8.12	2.47	0.40	10.99	1	090
27003		A	INCISION OF HIP TENDON	6.88	7.14	1.13	15.15	1	090
27005		A	INCISION OF HIP TENDON	9.48	3.55	0.58	13.61	1	090
27006		A	INCISION OF HIP TENDONS	10.02	9.32	1.55	20.89	1	090
27025		A	INCISION OF HIP/THIGH FASCIA	10.71	10.43	1.61	22.75	1	090
27030		A	DRAINAGE OF HIP JOINT	12.73	12.04	1.95	26.72	1	090
27033		A	EXPLORATION OF HIP JOINT	13.04	12.14	1.94	27.12	1	090
27035		A	DENERVATION OF HIP JOINT	16.56	12.50	2.32	31.38	1	090
27040		A	BIOPSY OF SOFT TISSUES	3.44	0.76	0.11	4.31	1	010
27041		A	BIOPSY OF SOFT TISSUES	9.85	2.82	0.46	13.13	1	090
27047		A	REMOVE HIP/PELVIS LESION	7.55	2.00	0.33	9.88	1	090
27048		A	REMOVE HIP/PELVIS LESION	6.01	4.57	0.86	11.44	1	090
27049		A	REMOVE TUMOR, HIP/PELVIS	13.20	10.69	1.96	25.85	1	090
27050		A	BIOPSY OF SACROILIAC JOINT	3.93	6.03	0.95	10.91	1	090
27052		A	BIOPSY OF HIP JOINT	5.74	10.66	1.68	18.08	1	090
27054		A	REMOVAL OF HIP JOINT LINING	8.00	14.66	2.39	25.05	1	090
27060		A	REMOVAL OF ISCHIAL BURSA	4.98	4.14	0.72	9.84	1	090
27062		A	REMOVE FEMUR LESION/BURSA	4.99	4.46	0.74	10.19	1	090
27065		A	REMOVAL OF HIP BONE LESION	5.26	5.88	0.95	12.09	1	090
27066		A	REMOVAL OF HIP BONE LESION	9.66	8.33	1.37	19.36	1	090
27067		A	REMOVE/GRAFT HIP BONE LESION	13.32	12.25	2.04	27.61	1	090
27070		A	PARTIAL REMOVAL OF HIP BONE	10.10	7.81	1.28	19.19	1	090
27071		A	PARTIAL REMOVAL OF HIP BONE	10.78	8.95	1.53	21.26	1	090
27075		A	EXTENSIVE HIP SURGERY	16.70	14.27	2.45	33.42	1	090
27076		A	EXTENSIVE HIP SURGERY	18.90	17.25	2.75	38.90	1	090
27077		A	EXTENSIVE HIP SURGERY	22.43	20.00	3.41	45.84	1	090
27078		A	EXTENSIVE HIP SURGERY	12.50	9.69	1.76	23.95	1	090
27079		A	EXTENSIVE HIP SURGERY	12.76	9.11	1.75	23.62	1	090
27080		A	REMOVAL OF TAIL BONE	5.94	5.03	0.92	11.89	1	090
27086		A	REMOVE HIP FOREIGN BODY	1.91	0.62	0.07	2.60	2	010
27087		A	REMOVE HIP FOREIGN BODY	8.44	3.82	0.64	12.90	1	090
27090		A	REMOVAL OF HIP PROSTHESIS	12.64	9.58	1.54	23.76	1	090
27091		A	REMOVAL OF HIP PROSTHESIS	21.58	20.87	3.33	45.78	1	090
27093		A	INJECTION FOR HIP X-RAY	1.37	0.86	0.11	2.34	2	ZZZ
27095		A	INJECTION FOR HIP X-RAY	1.58	0.98	0.13	2.69	2	ZZZ
27097		A	REVISION OF HIP TENDON	8.52	8.13	1.33	17.98	1	090
27098		A	TRANSFER TENDON TO PELVIS	8.52	8.13	1.33	17.98	1	090
27100		A	TRANSFER OF ABDOMINAL MUSCLE	11.14	8.10	1.50	20.74	1	090
27105		A	TRANSFER OF SPINAL MUSCLE	11.87	6.21	1.44	19.52	1	090
27110		A	TRANSFER OF ILIOPSOAS MUSCLE	13.17	11.18	1.95	26.30	1	090
27111		A	TRANSFER OF ILIOPSOAS MUSCLE	12.06	12.25	1.74	26.05	1	090
27120		A	RECONSTRUCTION OF HIP SOCKET	17.31	19.07	3.11	39.49	1	090
27122		A	RECONSTRUCTION OF HIP SOCKET	14.29	19.15	3.10	36.54	1	090
27125		A	PARTIAL HIP REPLACEMENT	13.93	19.70	3.17	36.80	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
27130		A	TOTAL HIP REPLACEMENT	19.69	30.22	4.82	54.73	1	090
27132		A	TOTAL HIP REPLACEMENT	22.60	33.31	5.37	61.28	1	090
27134		A	REVISE HIP JOINT REPLACEMENT	25.86	39.30	6.28	71.44	1	090
27137		A	REVISE HIP JOINT REPLACEMENT	19.68	31.56	5.07	56.31	1	090
27138		A	REVISE HIP JOINT REPLACEMENT	19.95	30.26	4.82	55.03	1	090
27140		A	TRANSPLANT OF FEMUR RIDGE	12.05	11.64	1.80	25.49	1	090
27146		A	INCISION OF HIP BONE	14.45	11.46	1.42	27.33	1	090
27147		A	REVISION OF HIP BONE	18.53	17.89	2.91	39.33	1	090
27151		A	INCISION OF HIP BONES	19.58	18.67	3.06	41.31	1	090
27156		A	REVISION OF HIP BONES	21.24	19.30	3.24	43.78	1	090
27158		A	REVISION OF PELVIS	19.07	15.19	2.79	37.05	1	090
27161		A	INCISION OF NECK OF FEMUR	16.02	15.08	2.44	33.54	1	090
27165		A	INCISION/FIXATION OF FEMUR	17.08	17.66	2.78	37.52	1	090
27170		A	REPAIR/GRAFT FEMUR HEAD/NECK	15.71	17.29	2.80	35.80	1	090
27175		A	TREAT SLIPPED EPIPHYSIS	7.63	1.24	0.19	9.06	1	090
27176		A	TREAT SLIPPED EPIPHYSIS	11.48	10.95	1.79	24.22	1	090
27177		A	REPAIR SLIPPED EPIPHYSIS	14.49	13.05	2.16	29.70	1	090
27178		A	REPAIR SLIPPED EPIPHYSIS	11.34	11.03	1.64	24.01	1	090
27179		A	REVISE HEAD/NECK OF FEMUR	12.32	11.75	1.92	25.99	1	090
27181		A	REPAIR SLIPPED EPIPHYSIS	14.53	13.86	2.27	30.66	1	090
27185		A	REVISION OF FEMUR EPIPHYSIS	8.74	2.92	0.92	12.58	1	090
27187		A	REINFORCE HIP BONES	13.25	18.29	2.91	34.45	1	090
27190		A	TREATMENT OF SACRUM FRACTURE	2.05	2.72	0.40	5.17	2	090
27192		A	REPAIR OF SACRUM FRACTURE	12.63	12.04	1.97	26.64	1	090
27195		A	TREAT PELVIS DISLOCATION	3.01	2.54	0.41	5.96	2	090
27196		A	TREAT PELVIS DISLOCATION	9.21	8.25	1.26	18.72	1	090
27200		A	TREAT TAIL BONE FRACTURE	1.85	1.57	0.18	3.60	2	090
27201		A	REPAIR TAIL BONE FRACTURE	5.78	5.52	0.90	12.20	1	090
27202		A	REPAIR TAIL BONE FRACTURE	6.87	6.48	0.94	14.29	1	090
27210		A	TREAT PELVIS FRACTURE	4.89	4.54	0.70	10.13	1	090
27212		A	REPAIR PELVIS FRACTURE(S)	9.15	8.73	1.39	19.27	1	090
27214		A	REPAIR PELVIS FRACTURE(S)	13.43	15.33	2.46	31.22	1	090
27220		A	TREAT HIP SOCKET FRACTURE	5.54	4.49	0.68	10.71	2	090
27222		A	TREAT HIP SOCKET FRACTURE	11.54	6.71	1.08	19.33	1	090
27224		A	REPAIR HIP SOCKET FRACTURE	15.48	16.63	2.65	34.76	1	090
27225		A	REPAIR HIP SOCKET FRACTURE	20.11	21.02	3.37	44.50	1	090
27230		A	TREAT FRACTURE OF THIGH	5.21	3.48	0.43	9.12	2	090
27232		A	TREAT FRACTURE OF THIGH	9.81	9.46	1.54	20.81	1	090
27234		A	REPAIR FRACTURE OF THIGH	12.48	16.36	2.66	31.50	1	090
27235		A	REPAIR OF THIGH FRACTURE	11.61	17.18	2.74	31.53	1	090
27236		A	REPAIR OF THIGH FRACTURE	14.90	17.83	2.86	35.59	1	090
27238		A	TREATMENT OF THIGH FRACTURE	5.34	5.17	0.75	11.26	2	090
27240		A	TREATMENT OF THIGH FRACTURE	11.44	10.22	1.62	23.28	1	090
27242		A	REPAIR OF THIGH FRACTURE	15.11	15.33	2.48	32.92	1	090
27244		A	REPAIR OF THIGH FRACTURE	15.23	17.18	2.76	35.17	1	090
27246		A	TREATMENT OF THIGH FRACTURE	4.60	4.07	0.64	9.31	2	090
27248		A	REPAIR OF THIGH FRACTURE	10.26	13.71	2.22	26.19	1	090
27250		A	TREAT HIP DISLOCATION	6.64	3.36	0.47	10.47	1	090
27252		A	TREAT HIP DISLOCATION	9.99	4.58	0.72	15.29	1	090
27253		A	REPAIR OF HIP DISLOCATION	12.62	13.86	2.22	28.70	1	090
27254		A	REPAIR OF HIP DISLOCATION	16.37	14.20	2.40	32.97	1	090
27255		A	REPAIR OF HIP DISLOCATION	19.43	19.28	3.17	41.88	1	090
27256		A	TREATMENT OF HIP DISLOCATION	3.92	1.97	0.32	6.21	2	010
27257		A	TREATMENT OF HIP DISLOCATION	5.07	4.87	0.77	10.71	2	010
27258		A	REPAIR OF HIP DISLOCATION	15.17	14.46	2.37	32.00	1	090
27259		A	REPAIR OF HIP DISLOCATION	19.00	18.12	2.97	40.09	1	090
27265		A	TREATMENT OF HIP DISLOCATION	5.87	3.65	0.58	10.10	1	090
27266		A	TREATMENT OF HIP DISLOCATION	8.15	4.69	0.75	13.59	1	090
27275		A	MANIPULATION OF HIP JOINT	2.11	1.98	0.31	4.40	2	010
27280		A	FUSION OF SACROILIAC JOINT	12.45	10.59	1.86	24.90	1	090
27282		A	FUSION OF PUBIC BONES	11.14	9.49	1.78	22.41	1	090
27284		A	FUSION OF HIP JOINT	16.46	15.28	2.53	34.27	1	090
27286		A	FUSION OF HIP JOINT	16.49	16.02	2.39	34.90	1	090
27290		A	AMPUTATION OF LEG AT HIP	22.85	18.43	3.12	44.40	1	090
27295		A	AMPUTATION OF LEG AT HIP	18.25	17.43	3.11	38.79	1	090
27299		C	PELVIS/HIP JOINT SURGERY	0.00	0.00	0.00	0.00		YYY
27301		A	DRAIN THIGH/KNEE LESION	6.29	2.59	0.42	9.30	1	090
27303		A	DRAINAGE OF BONE LESION	8.11	6.18	1.01	15.30	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
27305		A	INCISE THIGH TENDON & FASCIA	5.71	4.00	0.72	10.43	1	090
27306		A	INCISION OF THIGH TENDON	4.51	2.10	0.33	6.94	1	090
27307		A	INCISION OF THIGH TENDONS	5.59	3.17	0.51	9.27	1	090
27310		A	EXPLORATION OF KNEE JOINT	8.70	10.12	1.59	20.41	1	090
27315		A	PARTIAL REMOVAL, THIGH NERVE	6.86	5.67	1.01	13.54	1	090
27320		A	PARTIAL REMOVAL, THIGH NERVE	6.22	5.46	0.77	12.45	1	090
27323		A	BIOPSY THIGH SOFT TISSUES	2.82	0.96	0.13	3.91	1	010
27324		A	BIOPSY THIGH SOFT TISSUES	4.77	2.78	0.48	8.03	1	090
27327		A	REMOVAL OF THIGH LESION	4.56	2.42	0.42	7.40	1	090
27328		A	REMOVAL OF THIGH LESION	5.60	4.29	0.77	10.66	1	090
27329		A	REMOVE TUMOR, THIGH/KNEE	12.37	12.32	2.25	26.94	1	090
27330		A	BIOPSY KNEE JOINT LINING	4.96	8.29	1.26	14.51	1	090
27331		A	EXPLORE/TREAT KNEE JOINT	5.80	9.88	1.57	17.25	1	090
27332		A	REMOVAL OF KNEE CARTILAGE	8.27	11.58	1.82	21.67	1	090
27333		A	REMOVAL OF KNEE CARTILAGE	7.18	16.50	2.65	26.33	1	090
27334		A	REMOVE KNEE JOINT LINING	8.38	11.81	1.86	22.05	1	090
27335		A	REMOVE KNEE JOINT LINING	9.68	13.42	2.16	25.26	1	090
27340		A	REMOVAL OF KNEECAP BURSA	4.12	4.05	0.66	8.83	1	090
27345		A	REMOVAL OF KNEE CYST	5.94	5.94	1.00	12.88	1	090
27350		A	REMOVAL OF KNEECAP	7.82	10.20	1.63	19.65	1	090
27355		A	REMOVE FEMUR LESION	7.44	7.98	1.30	16.72	1	090
27356		A	REMOVE FEMUR LESION/GRAFT	9.06	8.64	1.41	19.11	1	090
27357		A	REMOVE FEMUR LESION/GRAFT	10.15	9.28	1.51	20.94	1	090
27358		A	REMOVE FEMUR LESION/FIXATION	4.99	4.79	0.76	10.54	2	ZZZ
27360		A	PARTIAL REMOVAL LEG BONE(S)	9.72	9.02	1.48	20.22	1	090
27365		A	EXTENSIVE LEG SURGERY	14.58	14.69	2.56	31.83	1	090
27370		A	INJECTION FOR KNEE X-RAY	1.01	0.64	0.05	1.70	2	ZZZ
27372		A	REMOVAL OF FOREIGN BODY	5.06	3.61	0.58	9.25	1	090
27380		A	REPAIR OF KNEECAP TENDON	6.98	8.37	1.36	16.71	1	090
27381		A	REPAIR/GRAFT KNEECAP TENDON	10.18	11.88	1.91	23.97	1	090
27385		A	REPAIR OF THIGH MUSCLE	7.56	9.32	1.50	18.38	1	090
27386		A	REPAIR/GRAFT OF THIGH MUSCLE	10.24	13.31	2.13	25.68	1	090
27390		A	INCISION OF THIGH TENDON	5.15	4.60	0.75	10.50	1	090
27391		A	INCISION OF THIGH TENDONS	7.03	5.71	0.95	13.69	1	090
27392		A	INCISION OF THIGH TENDONS	8.97	8.09	1.35	18.41	1	090
27393		A	LENGTHENING OF THIGH TENDON	6.27	5.98	0.98	13.23	1	090
27394		A	LENGTHENING OF THIGH TENDONS	8.40	6.04	0.99	15.43	1	090
27395		A	LENGTHENING OF THIGH TENDONS	11.55	11.05	1.74	24.34	1	090
27396		A	TRANSPLANT OF THIGH TENDON	7.72	7.44	1.16	16.32	1	090
27397		A	TRANSPLANTS OF THIGH TENDONS	9.82	9.36	1.53	20.71	1	090
27400		A	REVISE THIGH MUSCLES/TENDONS	8.92	8.32	1.31	18.55	1	090
27403		A	REPAIR OF KNEE CARTILAGE	8.22	9.27	1.52	19.01	1	090
27405		A	REPAIR OF KNEE LIGAMENT	8.40	10.72	1.76	20.88	1	090
27407		A	REPAIR OF KNEE LIGAMENT	9.96	9.35	1.50	20.81	1	090
27409		A	REPAIR OF KNEE LIGAMENTS	12.44	16.01	2.61	31.06	1	090
27418		A	REPAIR DEGENERATED KNEECAP	10.35	12.89	1.94	25.18	1	090
27420		A	REVISION OF UNSTABLE KNEECAP	9.64	11.58	1.83	23.05	1	090
27422		A	REVISION OF UNSTABLE KNEECAP	9.59	12.07	1.92	23.58	1	090
27424		A	REVISION/REMOVAL OF KNEECAP	9.62	12.77	2.00	24.39	1	090
27425		A	LATERAL RETINACULAR RELEASE	5.32	7.14	1.13	13.59	1	090
27427		A	RECONSTRUCTION, KNEE	9.15	14.86	2.37	26.38	1	090
27428		A	RECONSTRUCTION, KNEE	11.25	17.40	2.86	31.51	1	090
27429		A	RECONSTRUCTION, KNEE	12.50	11.88	1.92	26.30	1	090
27430		A	REVISION OF THIGH MUSCLES	9.40	9.85	1.58	20.83	1	090
27435		A	INCISION OF KNEE JOINT	9.22	7.41	1.19	17.82	1	090
27437		A	REVISE KNEECAP	8.16	11.01	1.64	20.81	1	090
27438		A	REVISE KNEECAP WITH IMPLANT	10.84	13.83	2.25	26.92	1	090
27440		A	REVISION OF KNEE JOINT	10.01	12.47	2.21	24.69	1	090
27441		A	REVISION OF KNEE JOINT	10.34	9.63	1.59	21.56	1	090
27442		A	REVISION OF KNEE JOINT	11.74	19.83	3.21	34.78	1	090
27443		A	REVISION OF KNEE JOINT	10.73	21.47	3.52	35.72	1	090
27445		A	REVISION OF KNEE JOINT	17.27	29.82	4.44	51.53	1	090
27446		A	REVISION OF KNEE JOINT	15.84	25.86	4.07	45.77	1	090
27447		A	TOTAL KNEE REPLACEMENT	20.75	32.61	5.21	58.57	2	090
27448		A	INCISION OF THIGH	10.80	13.56	2.20	26.56	1	090
27450		A	INCISION OF THIGH	13.78	15.63	2.49	31.90	1	090
27454		A	REALIGNMENT OF THIGH BONE	12.92	12.24	2.02	27.18	1	090
27455		A	REALIGNMENT OF KNEE	12.65	12.65	2.06	27.36	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
27457		A	REALIGNMENT OF KNEE	13.28	14.02	2.25	29.55	1	090
27465		A	SHORTENING OF THIGH BONE	13.53	12.90	2.11	28.54	1	090
27466		A	LENGTHENING OF THIGH BONE	15.89	14.15	2.40	32.44	1	090
27468		A	SHORTEN/LENGTHEN THIGHS	18.61	17.74	2.90	39.25	1	090
27470		A	REPAIR OF THIGH	15.61	17.57	2.74	35.92	1	090
27472		A	REPAIR/GRAFT OF THIGH	17.28	20.93	3.33	41.54	1	090
27475		A	SURGERY TO STOP LEG GROWTH	8.55	8.16	1.34	18.05	1	090
27477		A	SURGERY TO STOP LEG GROWTH	9.81	17.31	2.71	29.83	1	090
27479		A	SURGERY TO STOP LEG GROWTH	12.84	12.25	2.00	27.09	1	090
27485		A	SURGERY TO STOP LEG GROWTH	8.75	8.34	1.37	18.46	1	090
27486		A	REVISE KNEE JOINT REPLACE	17.52	28.29	4.50	50.31	1	090
27487		A	REVISE KNEE JOINT REPLACE	22.86	39.32	6.30	68.48	1	090
27488		A	REMOVAL OF KNEE PROSTHESIS	15.25	17.03	2.72	35.00	1	090
27495		A	REINFORCE THIGH	15.03	18.58	2.97	36.58	1	090
27500		A	TREATMENT OF THIGH FRACTURE	5.58	5.70	0.86	12.14	2	090
27502		A	TREATMENT OF THIGH FRACTURE	10.03	8.09	1.28	19.40	1	090
27504		A	REPAIR OF THIGH FRACTURE	12.25	10.15	1.66	24.06	1	090
27506		A	REPAIR OF THIGH FRACTURE	16.30	16.88	2.70	35.88	1	090
27508		A	TREATMENT OF THIGH FRACTURE	5.49	4.45	0.69	10.63	2	090
27510		A	TREATMENT OF THIGH FRACTURE	8.63	7.19	1.14	16.96	1	090
27512		A	REPAIR OF THIGH FRACTURE	13.01	12.25	1.98	27.24	1	090
27514		A	REPAIR OF THIGH FRACTURE	16.84	16.61	2.66	36.11	1	090
27516		A	REPAIR OF THIGH GROWTH PLATE	5.18	5.07	0.75	11.00	2	090
27517		A	REPAIR OF THIGH GROWTH PLATE	8.64	8.24	1.35	18.23	1	090
27518		A	REPAIR OF THIGH GROWTH PLATE	12.18	11.62	1.90	25.70	1	090
27519		A	REPAIR OF THIGH GROWTH PLATE	14.56	13.36	2.16	30.08	1	090
27520		A	TREAT KNEECAP FRACTURE	2.83	3.20	0.48	6.51	2	090
27522		A	REPAIR OF KNEECAP FRACTURE	7.58	7.31	1.08	15.97	1	090
27524		A	REPAIR OF KNEECAP FRACTURE	9.87	10.90	1.74	22.51	1	090
27530		A	TREATMENT OF KNEE FRACTURE	3.40	3.59	0.55	7.54	2	090
27532		A	TREATMENT OF KNEE FRACTURE	7.18	5.99	0.96	14.13	1	090
27534		A	REPAIR OF KNEE FRACTURE	11.60	11.19	1.78	24.57	1	090
27536		A	REPAIR OF KNEE FRACTURE	13.36	12.32	1.97	27.65	1	090
27537		A	REPAIR/GRAFT KNEE FRACTURE	15.21	17.93	2.87	36.01	1	090
27538		A	TREAT KNEE FRACTURE(S)	4.89	3.55	0.55	8.99	1	090
27540		A	REPAIR OF KNEE FRACTURE	13.04	11.54	1.83	26.41	1	090
27550		A	TREAT KNEE DISLOCATION	5.82	2.71	0.37	8.90	1	090
27552		A	TREAT KNEE DISLOCATION	7.79	3.62	0.57	11.98	1	090
27554		A	REPAIR OF KNEE DISLOCATION	10.42	9.94	1.63	21.99	1	090
27556		A	REPAIR OF KNEE DISLOCATION	14.20	13.16	2.06	29.42	1	090
27557		A	REPAIR OF KNEE DISLOCATION	16.65	15.38	2.56	34.59	1	090
27560		A	TREAT KNEECAP DISLOCATION	3.84	1.51	0.16	5.51	1	090
27562		A	TREAT KNEECAP DISLOCATION	5.77	5.46	0.80	12.03	1	090
27564		A	REPAIR KNEECAP DISLOCATION	9.35	7.34	1.33	18.02	1	090
27566		A	REPAIR KNEECAP DISLOCATION	12.10	11.15	1.76	25.01	1	090
27570		A	FIXATION OF KNEE JOINT	1.78	1.81	0.29	3.88	2	010
27580		A	FUSION OF KNEE	12.92	16.82	2.70	32.44	1	090
27590		A	AMPUTATE LEG AT THIGH	10.79	9.60	1.89	22.28	1	090
27591		A	AMPUTATE LEG AT THIGH	11.69	12.41	2.22	26.32	1	090
27592		A	AMPUTATE LEG AT THIGH	9.23	8.55	1.70	19.48	1	090
27594		A	AMPUTATION FOLLOW-UP SURGERY	6.63	3.85	0.72	11.20	2	090
27596		A	AMPUTATION FOLLOW-UP SURGERY	10.15	7.77	1.50	19.42	1	090
27598		A	AMPUTATE LOWER LEG AT KNEE	10.08	10.57	1.87	22.52	1	090
27599		C	LEG SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
27600		A	DECOMPRESSION OF LOWER LEG	5.30	3.58	0.68	9.56	1	090
27601		A	DECOMPRESSION OF LOWER LEG	5.26	3.57	0.71	9.54	1	090
27602		A	DECOMPRESSION OF LOWER LEG	6.98	4.26	0.81	12.05	1	090
27603		A	DRAIN LOWER LEG LESION	4.65	2.51	0.43	7.59	1	090
27604		A	DRAIN LOWER LEG BURSA	4.46	1.07	0.14	5.67	1	090
27605		A	INCISION OF ACHILLES TENDON	2.97	1.24	0.14	4.35	2	010
27606		A	INCISION OF ACHILLES TENDON	4.07	2.23	0.36	6.66	1	010
27607		A	TREAT LOWER LEG BONE LESION	7.43	6.34	1.03	14.80	1	090
27610		A	EXPLORE/TREAT ANKLE JOINT	7.66	7.83	1.19	16.68	1	090
27612		A	EXPLORATION OF ANKLE JOINT	6.56	9.24	1.37	17.17	1	090
27613		A	BIOPSY LOWER LEG SOFT TISSUE	2.23	0.71	0.10	3.04	1	010
27614		A	BIOPSY LOWER LEG SOFT TISSUE	5.58	2.39	0.39	8.36	1	090
27615		A	REMOVE TUMOR, LOWER LEG	12.43	8.67	1.50	22.60	1	090
27618		A	REMOVE LOWER LEG LESION	5.20	2.21	0.33	7.74	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPDS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
27619		A	REMOVE LOWER LEG LESION	8.41	4.36	0.71	13.48	1	090
27620		A	EXPLORE, TREAT ANKLE JOINT	6.00	6.36	1.01	13.37	1	090
27625		A	REMOVE ANKLE JOINT LINING	8.31	9.19	1.34	18.84	1	090
27626		A	REMOVE ANKLE JOINT LINING	8.94	12.07	1.32	22.33	1	090
27630		A	REMOVAL OF TENDON LESION	4.90	3.26	0.49	8.65	1	090
27635		A	REMOVE LOWER LEG BONE LESION	7.68	8.48	1.34	17.50	1	090
27637		A	REMOVE/GRAFT LEG BONE LESION	9.63	8.92	1.48	20.03	1	090
27638		A	REMOVE/GRAFT LEG BONE LESION	10.42	9.64	1.60	21.66	1	090
27640		A	PARTIAL REMOVAL OF TIBIA	10.76	10.34	1.66	22.76	1	090
27641		A	PARTIAL REMOVAL OF FIBULA	8.80	7.51	1.24	17.55	1	090
27645		A	EXTENSIVE LOWER LEG SURGERY	13.85	12.26	2.09	28.20	1	090
27646		A	EXTENSIVE LOWER LEG SURGERY	12.32	11.33	1.80	25.45	1	090
27647		A	EXTENSIVE ANKLE/HEEL SURGERY	11.81	10.48	1.42	23.71	1	090
27648		A	INJECTION FOR ANKLE X-RAY	1.01	0.56	0.05	1.62	2	000
27650		A	REPAIR ACHILLES TENDON	7.61	9.46	1.49	18.56	1	090
27652		A	REPAIR/GRAFT ACHILLES TENDON	8.19	10.98	1.65	20.82	1	090
27654		A	REPAIR OF ACHILLES TENDON	9.83	11.52	1.74	23.09	1	090
27656		A	REPAIR LEG FASCIA DEFECT	4.55	3.35	0.58	8.48	1	090
27658		A	REPAIR OF LEG TENDON, EACH	4.86	4.56	0.64	10.06	1	090
27659		A	REPAIR OF LEG TENDON, EACH	6.61	6.19	0.91	13.71	1	090
27664		A	REPAIR OF LEG TENDON, EACH	4.57	3.60	0.56	8.73	1	090
27665		A	REPAIR OF LEG TENDON, EACH	5.39	5.21	0.80	11.40	1	090
27675		A	REPAIR LOWER LEG TENDONS	7.15	6.75	0.99	14.89	1	090
27676		A	REPAIR LOWER LEG TENDONS	8.29	7.96	1.20	17.45	1	090
27680		A	RELEASE OF LOWER LEG TENDON	5.66	4.34	0.65	10.65	1	090
27681		A	RELEASE OF LOWER LEG TENDONS	6.70	6.30	0.91	13.91	1	090
27685		A	REVISION OF LOWER LEG TENDON	6.41	4.03	0.43	10.87	1	090
27686		A	REVISE LOWER LEG TENDONS	7.30	6.91	0.95	15.16	1	090
27687		A	REVISION OF CALF TENDON	6.15	5.74	0.80	12.69	1	090
27690		A	REVISE LOWER LEG TENDON	8.53	7.11	0.93	16.57	1	090
27691		A	REVISE LOWER LEG TENDON	9.74	8.32	1.30	19.36	1	090
27692		A	REVISE ADDITIONAL LEG TENDON	1.96	1.87	0.31	4.14	1	222
27695		A	REPAIR OF ANKLE LIGAMENT	6.42	8.96	1.39	16.77	1	090
27696		A	REPAIR OF ANKLE LIGAMENTS	8.14	7.44	1.22	16.80	1	090
27698		A	REPAIR OF ANKLE LIGAMENT	7.76	12.98	1.95	22.69	1	090
27700		A	REVISION OF ANKLE JOINT	9.14	12.73	1.59	23.46	1	090
27702		A	RECONSTRUCT ANKLE JOINT	13.32	25.85	4.20	43.37	1	090
27703		A	RECONSTRUCTION, ANKLE JOINT	15.26	14.55	2.38	32.19	1	090
27704		A	REMOVAL OF ANKLE IMPLANT	7.59	6.16	1.03	14.78	1	090
27705		A	INCISION OF TIBIA	10.15	11.31	1.85	23.31	1	090
27707		A	INCISION OF FIBULA	3.91	5.13	0.83	9.87	1	090
27709		A	INCISION OF TIBIA & FIBULA	9.63	13.88	2.25	25.76	1	090
27712		A	REALIGNMENT OF LOWER LEG	12.45	11.58	1.72	25.75	1	090
27715		A	REVISION OF LOWER LEG	13.66	13.29	1.97	28.92	1	090
27720		A	REPAIR OF TIBIA	11.54	14.73	2.38	28.65	1	090
27722		A	REPAIR/GRAFT OF TIBIA	11.51	11.07	1.73	24.31	1	090
27724		A	REPAIR/GRAFT OF TIBIA	12.76	18.61	3.02	34.39	1	090
27725		A	REPAIR OF LOWER LEG	11.63	11.00	1.62	24.25	1	090
27727		A	REPAIR OF LOWER LEG	13.58	9.87	1.93	25.38	1	090
27730		A	REPAIR OF TIBIA EPIPHYSIS	7.25	3.79	0.88	11.92	1	090
27732		A	REPAIR OF FIBULA EPIPHYSIS	5.34	5.09	0.83	11.26	1	090
27734		A	REPAIR LOWER LEG EPIPHYSES	8.32	7.94	1.30	17.56	1	090
27740		A	REPAIR OF LEG EPIPHYSES	9.23	8.81	1.44	19.48	1	090
27742		A	REPAIR OF LEG EPIPHYSES	10.25	9.78	1.60	21.63	1	090
27745		A	REINFORCE TIBIA	9.89	9.45	1.47	20.81	1	090
27750		A	TREATMENT OF TIBIA FRACTURE	3.05	3.64	0.54	7.23	2	090
27752		A	TREATMENT OF TIBIA FRACTURE	5.44	5.37	0.85	11.66	1	090
27754		A	REPAIR OF TIBIA FRACTURE	6.98	6.25	0.96	14.19	1	090
27756		A	REPAIR OF TIBIA FRACTURE	10.73	11.13	1.79	23.65	1	090
27758		A	REPAIR OF TIBIA FRACTURE	12.86	14.47	2.33	29.66	1	090
27760		A	TREATMENT OF ANKLE FRACTURE	2.96	2.72	0.38	6.06	2	090
27762		A	TREATMENT OF ANKLE FRACTURE	5.05	3.54	0.54	9.13	1	090
27764		A	REPAIR OF ANKLE FRACTURE	6.19	4.30	0.63	11.12	1	090
27766		A	REPAIR OF ANKLE FRACTURE	8.01	8.29	1.33	17.63	1	090
27780		A	TREATMENT OF FIBULA FRACTURE	2.60	2.08	0.27	4.95	2	090
27781		A	TREATMENT OF FIBULA FRACTURE	4.43	3.47	0.52	8.42	1	090
27782		A	REPAIR OF FIBULA FRACTURE	4.83	4.87	0.63	10.33	1	090
27784		A	REPAIR OF FIBULA FRACTURE	6.80	5.88	0.92	13.60	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
27786		A	TREATMENT OF ANKLE FRACTURE	2.81	2.65	0.39	5.85	2	090
27788		A	TREATMENT OF ANKLE FRACTURE	4.48	3.45	0.54	8.47	1	090
27790		A	REPAIR OF ANKLE FRACTURE	5.24	4.04	0.58	9.86	1	090
27792		A	REPAIR OF ANKLE FRACTURE	7.42	7.78	1.23	16.43	1	090
27800		A	TREAT LOWER LEG FRACTURES	3.32	3.83	0.54	7.69	2	090
27802		A	TREAT LOWER LEG FRACTURES	7.09	6.88	1.09	15.06	1	090
27804		A	REPAIR LOWER LEG FRACTURES	8.49	8.40	1.35	18.24	1	090
27806		A	REPAIR LOWER LEG FRACTURES	10.30	12.70	2.04	25.04	1	090
27808		A	TREATMENT OF ANKLE FRACTURE	2.78	2.94	0.41	6.13	2	090
27810		A	TREATMENT OF ANKLE FRACTURE	5.07	5.33	0.84	11.24	1	090
27812		A	REPAIR OF ANKLE FRACTURE	6.21	6.17	1.01	13.39	1	090
27814		A	REPAIR OF ANKLE FRACTURE	10.40	10.53	1.69	22.62	1	090
27816		A	TREATMENT OF ANKLE FRACTURE	2.86	4.03	0.59	7.48	2	090
27818		A	TREATMENT OF ANKLE FRACTURE	5.36	7.03	1.11	13.50	1	090
27820		A	REPAIR OF ANKLE FRACTURE	7.42	7.08	1.15	15.65	1	090
27822		A	REPAIR OF ANKLE FRACTURE	8.84	12.34	1.98	23.16	1	090
27823		A	REPAIR OF ANKLE FRACTURE	11.49	13.47	2.16	27.12	1	090
27830		A	TREAT LOWER LEG DISLOCATION	3.69	3.43	0.49	7.61	1	090
27831		A	TREAT LOWER LEG DISLOCATION	4.51	4.19	0.63	9.33	1	090
27832		A	REPAIR LOWER LEG DISLOCATION	6.28	6.01	0.94	13.23	1	090
27840		A	TREAT ANKLE DISLOCATION	4.51	1.96	0.22	6.69	1	090
27842		A	TREAT ANKLE DISLOCATION	6.03	2.34	0.35	8.72	1	090
27844		A	REPAIR ANKLE DISLOCATION	8.12	7.34	1.14	16.60	1	090
27846		A	REPAIR ANKLE DISLOCATION	9.53	9.05	1.45	20.03	1	090
27848		A	REPAIR ANKLE DISLOCATION	11.02	8.81	1.39	21.22	1	090
27860		A	FIXATION OF ANKLE JOINT	2.42	1.47	0.24	4.13	2	010
27870		A	FUSION OF ANKLE JOINT	10.99	14.67	2.33	27.99	1	090
27871		A	FUSION OF TIBIOFIBULAR JOINT	9.01	8.21	1.28	18.50	1	090
27880		A	AMPUTATION OF LOWER LEG	11.26	8.81	1.69	21.76	1	090
27881		A	AMPUTATION OF LOWER LEG	11.48	11.40	1.96	24.84	1	090
27882		A	AMPUTATION OF LOWER LEG	8.22	7.76	1.50	17.48	1	090
27884		A	AMPUTATION FOLLOW-UP SURGERY	7.80	3.55	0.65	12.00	1	090
27886		A	AMPUTATION FOLLOW-UP SURGERY	8.79	7.56	1.41	17.76	1	090
27888		A	AMPUTATION OF FOOT AT ANKLE	9.18	10.01	1.74	20.93	1	090
27889		A	AMPUTATION OF FOOT AT ANKLE	9.30	8.88	1.64	19.82	1	090
27899		C	LEG/ANKLE SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
28001		A	DRAINAGE OF BURSA OF FOOT	2.83	0.56	0.05	3.44	2	010
28002		A	TREATMENT OF FOOT INFECTION	3.96	2.38	0.34	6.68	2	010
28003		A	TREATMENT OF FOOT INFECTION	7.89	3.69	0.63	12.21	1	090
28005		A	TREAT FOOT BONE LESION	8.06	4.30	0.65	13.01	1	090
28008		A	INCISION OF FOOT FASCIA	4.42	2.83	0.30	7.55	1	090
28010		A	INCISION OF TOE TENDON	3.13	3.82	0.34	7.29	1	090
28011		A	INCISION OF TOE TENDONS	4.20	1.86	0.20	6.26	1	090
28020		A	EXPLORATION OF A FOOT JOINT	5.00	4.64	0.60	10.24	1	090
28022		A	EXPLORATION OF A FOOT JOINT	4.65	2.89	0.32	7.86	1	090
28024		A	EXPLORATION OF A TOE JOINT	4.34	2.52	0.25	7.11	1	090
28030		A	REMOVAL OF FOOT NERVE	6.09	4.14	0.44	10.67	1	090
28035		A	DECOMPRESSION OF TIBIA NERVE	5.08	7.11	0.95	13.14	1	090
28043		A	EXCISION OF FOOT LESION	3.60	1.82	0.21	5.63	1	090
28045		A	EXCISION OF FOOT LESION	4.70	4.20	0.49	9.39	1	090
28046		A	RESECTION OF TUMOR, FOOT	9.92	5.64	0.83	16.39	1	090
28050		A	BIOPSY OF FOOT JOINT LINING	4.20	4.10	0.48	8.78	1	090
28052		A	BIOPSY OF FOOT JOINT LINING	3.90	4.02	0.45	8.37	1	090
28054		A	BIOPSY OF TOE JOINT LINING	3.38	2.36	0.29	6.03	1	090
28060		A	PARTIAL REMOVAL FOOT FASCIA	5.33	4.45	0.57	10.35	1	090
28062		A	REMOVAL OF FOOT FASCIA	6.56	7.44	0.91	14.91	1	090
28070		A	REMOVAL OF FOOT JOINT LINING	4.98	4.72	0.51	10.21	1	090
28072		A	REMOVAL OF FOOT JOINT LINING	4.56	3.38	0.44	8.38	1	090
28080		A	REMOVAL OF FOOT LESION	3.35	4.44	0.48	8.27	1	090
28086		A	EXCISE FOOT TENDON SHEATH	4.76	4.46	0.62	9.84	1	090
28088		A	EXCISE FOOT TENDON SHEATH	3.82	3.82	0.42	8.06	1	090
28090		A	REMOVAL OF FOOT LESION	4.50	3.18	0.30	7.98	1	090
28092		A	REMOVAL OF TOE LESIONS	3.68	2.14	0.26	6.08	1	090
28100		A	REMOVAL OF ANKLE/HEEL LESION	5.66	4.82	0.60	11.08	1	090
28102		A	REMOVE/GRAFT FOOT LESION	7.70	7.21	0.89	15.80	1	090
28103		A	REMOVE/GRAFT FOOT LESION	6.43	5.90	0.73	13.06	1	090
28104		A	REMOVAL OF FOOT LESION	5.11	4.57	0.52	10.20	1	090
28106		A	REMOVE/GRAFT FOOT LESION	7.11	6.77	0.83	14.71	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
28107		A	REMOVE/GRAFT FOOT LESION	5.44	5.11	0.51	11.06	1	090
28108		A	REMOVAL OF TOE LESIONS	4.22	4.43	0.39	9.04	1	090
28110		A	PART REMOVAL OF METATARSAL	4.02	3.67	0.41	8.10	1	090
28111		A	PART REMOVAL OF METATARSAL	4.89	5.32	0.69	10.90	1	090
28112		A	PART REMOVAL OF METATARSAL	4.46	4.17	0.47	9.10	1	090
28113		A	PART REMOVAL OF METATARSAL	4.31	4.68	0.51	9.50	1	090
28114		A	REMOVAL OF METATARSAL HEADS	7.55	10.79	1.50	19.84	1	090
28116		A	REVISION OF FOOT	6.50	5.77	0.61	12.88	1	090
28118		A	REMOVAL OF HEEL BONE	5.85	6.02	0.70	12.57	1	090
28119		A	REMOVAL OF HEEL SPUR	5.38	5.73	0.61	11.72	1	090
28120		A	PART REMOVAL OF ANKLE/HEEL	6.92	5.32	0.71	12.95	1	090
28122		A	PARTIAL REMOVAL OF FOOT BONE	6.97	4.72	0.58	12.27	1	090
28124		A	PARTIAL REMOVAL OF TOE	4.63	4.33	0.38	9.34	1	090
28126		A	PARTIAL REMOVAL OF TOE	3.58	4.19	0.37	8.14	1	090
28130		A	REMOVAL OF ANKLE BONE	7.72	7.41	0.93	16.06	1	090
28140		A	REMOVAL OF METATARSAL	6.80	5.19	0.66	12.65	1	090
28150		A	REMOVAL OF TOE	4.03	3.47	0.40	7.90	1	090
28153		A	PARTIAL REMOVAL OF TOE	3.59	4.20	0.37	8.16	1	090
28160		A	PARTIAL REMOVAL OF TOE	3.79	4.34	0.39	8.52	1	090
28171		A	EXTENSIVE FOOT SURGERY	9.46	8.42	0.93	18.81	1	090
28173		A	EXTENSIVE FOOT SURGERY	8.62	7.59	0.95	17.16	1	090
28175		A	EXTENSIVE FOOT SURGERY	5.88	5.49	0.60	11.97	1	090
28190		A	REMOVAL OF FOOT FOREIGN BODY	2.02	0.56	0.05	2.63	2	010
28192		A	REMOVAL OF FOOT FOREIGN BODY	4.73	2.06	0.25	7.04	1	090
28193		A	REMOVAL OF FOOT FOREIGN BODY	5.73	2.51	0.31	8.55	1	090
28200		A	REPAIR OF FOOT TENDON	4.69	5.34	0.53	10.56	1	090
28202		A	REPAIR/GRAFT OF FOOT TENDON	6.72	6.13	0.81	13.66	1	090
28208		A	REPAIR OF FOOT TENDON	4.33	2.96	0.29	7.58	1	090
28210		A	REPAIR/GRAFT OF FOOT TENDON	6.27	5.89	0.64	12.80	1	090
28220		A	RELEASE OF FOOT TENDON	4.51	4.07	0.45	9.03	1	090
28222		A	RELEASE OF FOOT TENDONS	5.65	5.43	0.62	11.70	1	090
28225		A	RELEASE OF FOOT TENDON	3.61	2.50	0.26	6.37	1	090
28226		A	RELEASE OF FOOT TENDONS	4.51	3.57	0.42	8.50	1	090
28230		A	INCISION OF FOOT TENDON(S)	4.21	2.56	0.23	7.00	1	090
28232		A	INCISION OF TOE TENDON	3.44	1.69	0.15	5.28	1	090
28234		A	INCISION OF FOOT TENDON	3.36	1.61	0.14	5.11	1	090
28236		A	TRANSFER OF FOOT TENDON	8.45	7.92	1.14	17.51	1	090
28238		A	REVISION OF FOOT TENDON	7.66	7.62	0.89	16.17	1	090
28240		A	RELEASE OF BIG TOE	4.34	2.24	0.24	6.82	1	090
28250		A	REVISION OF FOOT FASCIA	5.97	4.70	0.53	11.20	1	090
28260		A	RELEASE OF MIDFOOT JOINT	7.90	4.67	0.51	13.08	1	090
28261		A	REVISION OF FOOT TENDON	9.40	6.23	0.62	16.25	1	090
28262		A	REVISION OF FOOT AND ANKLE	12.85	12.55	1.52	26.92	1	090
28264		A	RELEASE OF MIDFOOT JOINT	10.33	10.08	1.23	21.64	1	090
28270		A	RELEASE OF FOOT CONTRACTURE	4.82	2.77	0.24	7.83	1	090
28272		A	RELEASE OF TOE JOINT, EACH	3.87	2.15	0.19	6.21	1	090
28280		A	FUSION OF TOES	5.19	2.34	0.31	7.84	1	090
28285		A	REPAIR OF HAMMERTOE	3.77	4.61	0.41	8.79	1	090
28286		A	REPAIR OF HAMMERTOE	4.65	3.78	0.39	8.82	1	090
28288		A	PARTIAL REMOVAL OF FOOT BONE	3.93	3.95	0.45	8.33	1	090
28290		A	CORRECTION OF BUNION	5.66	5.65	0.67	11.98	1	090
28292		A	CORRECTION OF BUNION	6.57	7.43	0.78	14.78	1	090
28293		A	CORRECTION OF BUNION	8.69	10.07	1.03	19.79	1	090
28294		A	CORRECTION OF BUNION	8.58	9.65	0.91	19.14	1	090
28296		A	CORRECTION OF BUNION	9.17	9.29	1.03	19.49	1	090
28297		A	CORRECTION OF BUNION	9.16	9.50	1.10	19.76	1	090
28298		A	CORRECTION OF BUNION	7.92	9.37	0.83	18.12	1	090
28299		A	CORRECTION OF BUNION	8.91	10.69	1.13	20.73	1	090
28300		A	INCISION OF HEEL BONE	9.61	6.87	0.83	17.31	1	090
28302		A	INCISION OF ANKLE BONE	9.62	9.37	1.17	20.16	1	090
28304		A	INCISION OF MIDFOOT BONES	9.14	6.79	0.74	16.67	1	090
28305		A	INCISE/GRAFT MIDFOOT BONES	10.52	10.38	1.08	21.98	1	090
28306		A	INCISION OF METATARSAL	6.02	4.81	0.50	11.33	1	090
28307		A	INCISION OF METATARSAL	6.37	6.19	0.80	13.36	2	090
28308		A	INCISION OF METATARSAL	5.37	6.02	0.53	11.92	1	090
28309		A	INCISION OF METATARSALS	9.31	7.24	1.05	17.60	1	090
28310		A	REVISION OF BIG TOE	5.34	4.40	0.44	10.18	1	090
28312		A	REVISION OF TOE	4.53	4.80	0.48	9.81	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPs*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
28313		A	REPAIR DEFORMITY OF TOE	5.00	2.71	0.32	8.03	1	090
28315		A	REMOVAL OF SESAMOID BONE	4.84	4.47	0.43	9.74	1	090
28320		A	REPAIR OF FOOT BONES	9.24	9.16	1.08	19.48	1	090
28322		A	REPAIR OF METATARSALS	8.47	4.92	0.56	13.95	1	090
28340		A	RESECT ENLARGED TOE TISSUE	6.93	6.68	0.96	14.57	1	090
28341		A	RESECT ENLARGED TOE	8.28	8.07	1.01	17.36	1	090
28344		A	REPAIR EXTRA TOE(S)	4.09	3.90	0.64	8.63	1	090
28345		A	REPAIR WEBBED TOE(S)	5.81	5.32	0.75	11.88	1	090
28360		C	RECONSTRUCT CLEFT FOOT	0.00	0.00	0.00	0.00		090
28400		A	TREATMENT OF HEEL FRACTURE	2.12	2.90	0.42	5.44	2	090
28405		A	TREATMENT OF HEEL FRACTURE	4.52	4.10	0.62	9.24	1	090
28406		A	TREATMENT OF HEEL FRACTURE	6.13	6.42	0.98	13.53	1	090
28410		A	REPAIR OF HEEL FRACTURE	5.60	5.43	0.71	11.74	1	090
28415		A	REPAIR OF HEEL FRACTURE	9.89	9.50	1.47	20.86	1	090
28420		A	REPAIR/GRAFT HEEL FRACTURE	11.92	11.48	1.72	25.12	1	090
28430		A	TREATMENT OF ANKLE FRACTURE	2.07	2.58	0.36	5.01	2	090
28435		A	TREATMENT OF ANKLE FRACTURE	3.43	3.54	0.53	7.50	1	090
28436		A	TREATMENT OF ANKLE FRACTURE	4.64	4.42	0.72	9.78	1	090
28440		A	REPAIR OF ANKLE FRACTURE	4.10	3.78	0.26	8.14	1	090
28445		A	REPAIR OF ANKLE FRACTURE	9.26	9.28	1.48	20.02	1	090
28450		A	TREAT MIDFOOT FRACTURE, EACH	1.86	1.96	0.26	4.08	2	090
28455		A	TREAT MIDFOOT FRACTURE, EACH	3.10	2.67	0.35	6.12	1	090
28456		A	REPAIR MIDFOOT FRACTURE	2.52	2.40	0.39	5.31	1	090
28460		A	REPAIR MIDFOOT FRACTURE, EACH	6.44	6.21	0.71	13.36	1	090
28465		A	REPAIR MIDFOOT FRACTURE, EACH	6.90	5.83	0.85	13.58	1	090
28470		A	TREAT METATARSAL FRACTURE	1.85	1.89	0.24	3.98	1	090
28475		A	TREAT METATARSAL FRACTURE	2.89	2.47	0.31	5.67	1	090
28476		A	REPAIR METATARSAL FRACTURE	3.31	3.18	0.43	6.92	1	090
28480		A	REPAIR METATARSAL FRACTURE	4.01	2.97	0.40	7.38	1	090
28485		A	REPAIR METATARSAL FRACTURE	5.60	4.93	0.64	11.17	1	090
28490		A	TREAT BIG TOE FRACTURE	1.06	0.95	0.10	2.11	2	090
28495		A	TREAT BIG TOE FRACTURE	1.56	1.17	0.13	2.86	1	090
28496		A	REPAIR BIG TOE FRACTURE	2.29	2.18	0.32	4.79	1	090
28500		A	REPAIR BIG TOE FRACTURE	2.14	2.01	0.27	4.42	1	090
28505		A	REPAIR BIG TOE FRACTURE	3.74	3.15	0.45	7.34	1	090
28510		A	TREATMENT OF TOE FRACTURE	1.06	0.94	0.09	2.09	2	090
28515		A	TREATMENT OF TOE FRACTURE	1.44	1.17	0.11	2.72	1	090
28520		A	REPAIR OF TOE FRACTURE	1.85	1.68	0.22	3.75	1	090
28525		A	REPAIR OF TOE FRACTURE	3.24	2.17	0.30	5.71	1	090
28530		A	TREAT SESAMOID BONE FRACTURE	1.06	1.05	0.10	2.21	2	090
28540		A	TREAT FOOT DISLOCATION	2.00	0.64	0.06	2.70	1	090
28545		A	TREAT FOOT DISLOCATION	2.30	1.38	0.14	3.82	1	090
28546		A	TREAT FOOT DISLOCATION	3.04	2.89	0.47	6.40	1	090
28550		A	REPAIR FOOT DISLOCATION	2.72	2.68	0.27	5.67	1	090
28555		A	REPAIR FOOT DISLOCATION	6.15	5.87	0.77	12.79	1	090
28570		A	TREAT FOOT DISLOCATION	1.65	1.68	0.17	3.50	1	090
28575		A	TREAT FOOT DISLOCATION	3.07	2.92	0.44	6.43	1	090
28580		A	REPAIR FOOT DISLOCATION	2.71	0.42	0.06	3.19	1	090
28585		A	REPAIR FOOT DISLOCATION	7.86	5.24	0.59	13.69	1	090
28600		A	TREAT FOOT DISLOCATION	1.85	0.72	0.08	2.65	1	090
28605		A	TREAT FOOT DISLOCATION	2.55	2.39	0.35	5.29	1	090
28606		A	TREAT FOOT DISLOCATION	4.72	3.68	0.59	8.99	1	090
28610		A	REPAIR FOOT DISLOCATION	3.15	3.07	0.38	6.60	1	090
28615		A	REPAIR FOOT DISLOCATION	5.40	5.24	0.82	11.46	1	090
28630		A	TREAT TOE DISLOCATION	1.74	1.08	0.11	2.93	2	010
28635		A	TREAT TOE DISLOCATION	1.95	1.53	0.19	3.67	2	010
28640		A	REPAIR TOE DISLOCATION	2.02	1.98	0.22	4.22	1	090
28645		A	REPAIR TOE DISLOCATION	4.17	3.42	0.39	7.98	1	090
28660		A	TREAT TOE DISLOCATION	1.24	0.67	0.06	1.97	2	010
28665		A	TREAT TOE DISLOCATION	1.96	1.03	0.11	3.10	2	010
28670		A	REPAIR OF TOE DISLOCATION	1.70	1.58	0.22	3.50	1	090
28675		A	REPAIR OF TOE DISLOCATION	2.83	2.72	0.36	5.91	1	090
28705		A	FUSION OF FOOT BONES	11.27	10.88	1.67	23.82	1	090
28715		A	FUSION OF FOOT BONES	10.36	12.99	2.00	25.35	1	090
28725		A	FUSION OF FOOT BONES	9.14	9.95	1.52	20.61	1	090
28730		A	FUSION OF FOOT BONES	8.22	9.48	1.40	19.10	1	090
28735		A	FUSION OF FOOT BONES	10.60	10.29	1.45	22.34	1	090
28737		A	REVISION OF FOOT BONES	7.46	7.00	1.00	15.46	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
28740		A	FUSION OF FOOT BONES	6.53	5.42	0.76	12.71	1	090
28750		A	FUSION OF BIG TOE JOINT	5.02	5.61	0.86	11.49	1	090
28755		A	FUSION OF BIG TOE JOINT	4.72	3.89	0.48	9.09	1	090
28760		A	FUSION OF BIG TOE JOINT	5.76	5.69	0.69	12.14	1	090
28800		A	AMPUTATION OF MIDFOOT	7.77	7.01	1.25	16.03	1	090
28805		A	AMPUTATION THRU METATARSAL	7.95	6.66	1.28	15.89	1	090
28810		A	AMPUTATION TOE & METATARSAL	5.82	4.11	0.79	10.72	1	090
28820		A	AMPUTATION OF TOE	3.75	2.72	0.49	6.96	2	090
28825		A	PARTIAL AMPUTATION OF TOE	3.29	2.53	0.43	6.25	2	090
28899		C	FOOT/TOES SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
29000		A	APPLICATION OF BODY CAST	2.37	1.94	0.22	4.53	2	000
29010		A	APPLICATION OF BODY CAST	2.17	2.46	0.35	4.98	2	000
29015		A	APPLICATION OF BODY CAST	2.54	2.46	0.34	5.34	2	000
29020		A	APPLICATION OF BODY CAST	2.22	1.91	0.24	4.37	2	000
29025		A	APPLICATION OF BODY CAST	2.53	0.79	0.14	3.46	2	000
29035		A	APPLICATION OF BODY CAST	1.86	2.06	0.33	4.25	2	000
29040		A	APPLICATION OF BODY CAST	2.34	2.13	0.31	4.78	2	000
29044		A	APPLICATION OF BODY CAST	2.23	2.20	0.35	4.78	2	000
29046		A	APPLICATION OF BODY CAST	2.54	2.35	0.37	5.26	2	000
29049		A	APPLICATION OF SHOULDER CAST	0.94	0.44	0.06	1.44	2	000
29055		A	APPLICATION OF SHOULDER CAST	1.87	1.27	0.18	3.32	2	000
29058		A	APPLICATION OF SHOULDER CAST	1.38	0.69	0.09	2.16	2	000
29065		A	APPLICATION OF LONG ARM CAST	0.92	0.84	0.13	1.89	2	000
29075		A	APPLICATION OF FOREARM CAST	0.81	0.65	0.10	1.56	2	000
29085		A	APPLY HAND/WRIST CAST	0.92	0.53	0.08	1.53	2	000
29105		A	APPLY LONG ARM SPLINT	0.92	0.54	0.08	1.54	2	000
29125		A	APPLY FOREARM SPLINT	0.63	0.38	0.05	1.06	2	000
29126		A	APPLY FOREARM SPLINT	0.81	0.42	0.06	1.29	2	000
29130		A	APPLICATION OF FINGER SPLINT	0.53	0.18	0.02	0.73	2	000
29131		A	APPLICATION OF FINGER SPLINT	0.59	0.41	0.06	1.06	2	000
29200		A	STRAPPING OF CHEST	0.69	0.28	0.03	1.00	2	000
29220		A	STRAPPING OF LOW BACK	0.68	0.40	0.05	1.13	2	000
29240		A	STRAPPING OF SHOULDER	0.75	0.28	0.03	1.06	2	000
29260		A	STRAPPING OF ELBOW OR WRIST	0.59	0.24	0.03	0.86	2	000
29280		A	STRAPPING OF HAND OR FINGER	0.55	0.22	0.02	0.79	2	000
29305		A	APPLICATION OF HIP CAST	2.14	1.98	0.32	4.44	2	000
29325		A	APPLICATION OF HIP CASTS	2.45	2.05	0.29	4.79	2	000
29345		A	APPLICATION OF LONG LEG CAST	1.48	1.07	0.16	2.71	2	000
29355		A	APPLICATION OF LONG LEG CAST	1.61	1.15	0.17	2.93	2	000
29358		A	APPLY LONG LEG CAST BRACE	1.51	2.17	0.34	4.02	2	000
29365		A	APPLICATION OF LONG LEG CAST	1.24	0.91	0.14	2.29	2	000
29405		A	APPLY SHORT LEG CAST	0.91	0.83	0.12	1.86	2	000
29425		A	APPLY SHORT LEG CAST	1.06	1.02	0.14	2.22	2	000
29435		A	APPLY SHORT LEG CAST	1.24	1.24	0.19	2.67	2	000
29440		A	ADDITION OF WALKER TO CAST	0.61	0.24	0.03	0.88	2	000
29450		A	APPLICATION OF LEG CAST	1.07	0.41	0.04	1.52	2	000
29505		A	APPLICATION LONG LEG SPLINT	0.73	0.61	0.07	1.41	2	000
29515		A	APPLICATION LOWER LEG SPLINT	0.77	0.50	0.06	1.33	2	000
29520		A	STRAPPING OF HIP	0.58	0.37	0.03	0.98	2	000
29530		A	STRAPPING OF KNEE	0.61	0.36	0.05	1.02	2	000
29540		A	STRAPPING OF ANKLE	0.55	0.31	0.03	0.89	2	000
29550		A	STRAPPING OF TOES	0.50	0.29	0.03	0.82	2	000
29580		A	APPLICATION OF PASTE BOOT	0.61	0.32	0.04	0.97	2	000
29590		A	APPLICATION OF FOOT SPLINT	0.80	0.29	0.03	1.12	2	000
29700		A	REMOVAL/REVISION OF CAST	0.93	0.33	0.05	1.31	2	000
29705		A	REMOVAL/REVISION OF CAST	1.17	0.36	0.05	1.58	2	000
29710		A	REMOVAL/REVISION OF CAST	1.41	0.48	0.07	1.96	2	000
29715		A	REMOVAL/REVISION OF CAST	0.99	0.91	0.12	2.02	2	000
29720		A	REPAIR OF BODY CAST	0.72	0.24	0.04	1.00	2	000
29730		A	WINDOWING OF CAST	0.79	0.27	0.04	1.10	2	000
29740		A	WEDGING OF CAST	1.17	0.39	0.06	1.62	2	000
29750		A	WEDGING OF CLUBFOOT CAST	1.33	0.54	0.07	1.94	2	000
29799		C	CASTING/STRAPPING PROCEDURE	0.00	0.00	0.00	0.00		YYY
29800		A	JAW ARTHROSCOPY/SURGERY	4.25	3.22	0.38	7.85	2	090
29804		A	JAW ARTHROSCOPY/SURGERY	5.31	4.02	0.47	9.80	2	090
29815		A	SHOULDER ARTHROSCOPY	6.05	5.09	0.80	11.94	1	090
29819		A	SHOULDER ARTHROSCOPY/SURGERY	7.72	11.08	1.82	20.62	1	090
29820		A	SHOULDER ARTHROSCOPY/SURGERY	7.18	11.05	1.82	20.05	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
29821		A	SHOULDER ARTHROSCOPY/SURGERY	7.83	14.03	2.24	24.10	1	090
29822		A	SHOULDER ARTHROSCOPY/SURGERY	7.53	11.36	1.83	20.72	1	090
29823		A	SHOULDER ARTHROSCOPY/SURGERY	8.28	15.11	2.45	25.84	1	090
29825		A	SHOULDER ARTHROSCOPY/SURGERY	7.73	13.35	2.16	23.24	1	090
29826		A	SHOULDER ARTHROSCOPY/SURGERY	9.18	8.75	1.43	19.36	1	090
29830		A	ELBOW ARTHROSCOPY	5.93	5.61	0.87	12.41	1	090
29834		A	ELBOW ARTHROSCOPY/SURGERY	6.46	6.16	1.01	13.63	1	090
29835		A	ELBOW ARTHROSCOPY/SURGERY	6.67	6.36	1.04	14.07	1	090
29836		A	ELBOW ARTHROSCOPY/SURGERY	7.77	7.41	1.21	16.39	1	090
29837		A	ELBOW ARTHROSCOPY/SURGERY	7.08	6.75	1.11	14.94	1	090
29838		A	ELBOW ARTHROSCOPY/SURGERY	7.82	7.43	1.20	16.45	1	090
29840		A	WRIST ARTHROSCOPY	5.68	5.23	0.74	11.65	1	090
29843		A	WRIST ARTHROSCOPY/SURGERY	6.18	5.89	0.96	13.03	1	090
29844		A	WRIST ARTHROSCOPY/SURGERY	6.55	5.88	1.00	13.43	1	090
29845		A	WRIST ARTHROSCOPY/SURGERY	7.74	7.38	1.21	16.33	1	090
29846		A	WRIST ARTHROSCOPY/SURGERY	6.95	6.39	1.07	14.41	1	090
29847		A	WRIST ARTHROSCOPY/SURGERY	7.30	7.15	1.02	15.47	1	090
29848		A	WRIST ARTHROSCOPY/SURGERY	4.25	4.05	0.66	8.96	2	090
29870		A	KNEE ARTHROSCOPY, DIAGNOSTIC	5.20	4.23	0.68	10.11	1	090
29871		A	KNEE ARTHROSCOPY/DRAINAGE	6.62	7.14	1.01	14.77	1	090
29874		A	KNEE ARTHROSCOPY/SURGERY	7.16	10.32	1.60	19.08	1	090
29875		A	KNEE ARTHROSCOPY/SURGERY	6.49	10.59	1.70	18.78	1	090
29876		A	KNEE ARTHROSCOPY/SURGERY	7.91	12.72	2.06	22.69	1	090
29877		A	KNEE ARTHROSCOPY/SURGERY	7.43	11.83	1.90	21.16	1	090
29879		A	KNEE ARTHROSCOPY/SURGERY	8.03	14.21	2.30	24.54	1	090
29880		A	KNEE ARTHROSCOPY/SURGERY	8.53	14.53	2.34	25.40	1	090
29881		A	KNEE ARTHROSCOPY/SURGERY	7.86	11.88	1.91	21.65	1	090
29882		A	KNEE ARTHROSCOPY/SURGERY	8.68	12.39	2.01	23.08	1	090
29883		A	KNEE ARTHROSCOPY/SURGERY	9.48	18.07	2.95	30.50	1	090
29884		A	KNEE ARTHROSCOPY/SURGERY	7.29	10.16	1.65	19.10	1	090
29885		A	KNEE ARTHROSCOPY/SURGERY	9.10	8.67	1.42	19.19	1	090
29886		A	KNEE ARTHROSCOPY/SURGERY	7.51	7.17	1.17	15.85	1	090
29887		A	KNEE ARTHROSCOPY/SURGERY	9.04	11.09	1.80	21.93	1	090
29888		A	KNEE ARTHROSCOPY/SURGERY	11.26	10.36	1.65	23.27	1	090
29889		A	KNEE ARTHROSCOPY/SURGERY	11.34	10.81	1.77	23.92	1	090
29894		A	ANKLE ARTHROSCOPY/SURGERY	7.32	7.00	1.11	15.43	1	090
29895		A	ANKLE ARTHROSCOPY/SURGERY	7.09	10.29	1.59	18.97	1	090
29897		A	ANKLE ARTHROSCOPY/SURGERY	7.29	11.46	1.86	20.61	1	090
29898		A	ANKLE ARTHROSCOPY/SURGERY	8.47	13.18	2.02	23.67	1	090
29909		C	ARTHROSCOPY OF JOINT	0.00	0.00	0.00	0.00		YYY
30000		A	DRAINAGE OF NOSE LESION	1.46	0.62	0.05	2.13	2	010
30020		A	DRAINAGE OF NOSE LESION	1.46	0.64	0.06	2.16	2	010
30100		A	INTRANASAL BIOPSY	0.99	0.73	0.08	1.80	2	000
30110		A	REMOVAL OF NOSE POLYP(S)	1.67	1.36	0.14	3.17	1	010
30115		A	REMOVAL OF NOSE POLYP(S)	4.48	2.96	0.31	7.75	1	090
30117		A	REMOVAL OF INTRANASAL LESION	3.22	2.99	0.32	6.53	1	090
30118		A	REMOVAL OF INTRANASAL LESION	9.72	8.45	0.97	19.14	1	090
30120		A	REVISION OF NOSE	5.42	7.29	1.05	13.76	1	090
30124		A	REMOVAL OF NOSE LESION	3.16	1.41	0.16	4.73	1	090
30125		A	REMOVAL OF NOSE LESION	7.16	5.84	0.77	13.77	1	090
30130		A	REMOVAL OF TURBINATE BONES	3.34	1.76	0.18	5.28	1	090
30140		A	REMOVAL OF TURBINATE BONES	3.46	3.20	0.35	7.01	1	090
30150		A	PARTIAL REMOVAL OF NOSE	8.93	8.35	1.12	18.40	1	090
30160		A	REMOVAL OF NOSE	9.40	7.76	1.04	18.20	1	090
30200		A	INJECTION TREATMENT OF NOSE	0.82	0.38	0.04	1.24	2	000
30210		A	NASAL SINUS THERAPY	1.08	0.27	0.03	1.38	2	010
30220		A	INSERT NASAL SEPTAL BUTTON	1.57	1.59	0.16	3.32	1	010
30300		A	REMOVE NASAL FOREIGN BODY	1.04	0.49	0.05	1.58	2	010
30310		A	REMOVE NASAL FOREIGN BODY	2.02	1.71	0.19	3.92	1	010
30320		A	REMOVE NASAL FOREIGN BODY	4.63	4.53	0.45	9.61	1	090
30400		C	RECONSTRUCTION OF NOSE	0.00	0.00	0.00	0.00		090
30410		C	RECONSTRUCTION OF NOSE	0.00	0.00	0.00	0.00		090
30420		C	RECONSTRUCTION OF NOSE	0.00	0.00	0.00	0.00		090
30430		C	REVISION OF NOSE	0.00	0.00	0.00	0.00		090
30435		C	REVISION OF NOSE	0.00	0.00	0.00	0.00		090
30450		C	REVISION OF NOSE	0.00	0.00	0.00	0.00		090
30520		A	REPAIR OF NASAL SEPTUM	5.84	9.19	1.01	16.04	1	090
30540		A	REPAIR NASAL DEFECT	7.86	6.98	0.74	15.58	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
30545		A	REPAIR NASAL DEFECT	11.48	11.41	0.98	23.87	1	090
30560		A	RELEASE OF NASAL ADHESIONS	1.28	0.59	0.06	1.93	2	010
30580		A	REPAIR UPPER JAW FISTULA	6.84	6.57	0.61	14.02	1	090
30600		A	REPAIR MOUTH/NOSE FISTULA	6.19	3.97	0.37	10.53	1	090
30620		A	RECONSTRUCTION INNER NOSE	5.84	10.18	1.15	17.17	2	090
30630		A	REPAIR NASAL SEPTUM DEFECT	5.84	6.57	0.75	13.16	2	090
30800		D	CAUTERIZATION INNER NOSE	0.00	0.00	0.00	0.00		222
30801		A	CAUTERIZATION INNER NOSE	1.07	0.50	0.05	1.62	2	222
30802		A	CAUTERIZATION INNER NOSE	2.09	0.99	0.11	3.19	2	010
30805		D	CAUTERIZATION/ABLATION, MUCOSA	0.00	0.00	0.00	0.00		222
30820		D	CRYOSURGERY IN NOSE	0.00	0.00	0.00	0.00		222
30901		A	CONTROL OF NOSEBLEED	1.49	0.60	0.06	2.15	2	010
30903		A	CONTROL OF NOSEBLEED	1.84	0.90	0.08	2.82	2	010
30905		A	CONTROL OF NOSEBLEED	2.29	1.88	0.18	4.35	2	010
30906		A	REPEAT CONTROL OF NOSEBLEED	2.74	1.13	0.11	3.98	2	010
30915		A	LIGATION NASAL SINUS ARTERY	7.08	5.22	0.56	12.86	1	090
30920		A	LIGATION UPPER JAW ARTERY	7.86	12.92	1.39	22.17	1	090
30930		A	THERAPY FRACTURE OF NOSE	1.28	0.75	0.08	2.11	1	010
30999		C	NASAL SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
31000		A	IRRIGATION MAXILLARY SINUS	1.15	0.45	0.05	1.65	2	010
31002		A	IRRIGATION SPHENOID SINUS	1.95	0.49	0.05	2.49	2	010
31020		A	EXPLORATION MAXILLARY SINUS	2.96	2.81	0.30	6.07	1	090
31030		A	EXPLORATION MAXILLARY SINUS	5.89	8.58	0.91	15.38	1	090
31032		A	EXPLORE SINUS, REMOVE POLYPS	6.55	9.85	1.04	17.44	1	090
31040		A	EXPLORATION BEHIND UPPER JAW	9.31	8.41	0.91	18.63	1	090
31050		A	EXPLORATION SPHENOID SINUS	5.35	6.28	0.68	12.31	1	090
31051		A	SPHENOID SINUS SURGERY	7.22	8.56	0.90	16.68	1	090
31070		A	EXPLORATION OF FRONTAL SINUS	4.25	4.94	0.54	9.73	2	090
31071		A	EXPLORATION OF FRONTAL SINUS	5.04	4.20	0.22	9.46	2	222
31075		A	EXPLORATION OF FRONTAL SINUS	9.03	11.08	1.15	21.26	1	090
31080		A	REMOVAL OF FRONTAL SINUS	11.30	9.70	1.17	22.17	1	090
31081		A	REMOVAL OF FRONTAL SINUS	12.57	10.87	1.37	24.81	1	090
31084		A	REMOVAL OF FRONTAL SINUS	13.37	15.58	1.71	30.66	1	090
31085		A	REMOVAL OF FRONTAL SINUS	14.10	16.49	1.85	32.44	1	090
31086		A	REMOVAL OF FRONTAL SINUS	12.62	11.45	1.21	25.28	1	090
31087		A	REMOVAL OF FRONTAL SINUS	12.79	10.96	1.40	25.15	1	090
31090		A	EXPLORATION OF SINUSES	9.12	20.35	2.23	31.70	1	090
31200		A	REMOVAL OF ETHMOID SINUS	7.85	4.87	0.51	13.23	1	090
31201		A	REMOVAL OF ETHMOID SINUS	8.34	7.39	0.79	16.52	1	090
31205		A	REMOVAL OF ETHMOID SINUS	10.17	8.47	0.85	19.49	1	090
31225		A	REMOVAL OF UPPER JAW	16.01	20.55	2.50	39.06	1	090
31230		A	REMOVAL OF UPPER JAW	22.19	22.91	2.61	47.71	1	090
31250		A	NASAL ENDOSCOPY, DIAGNOSTIC	1.15	1.45	0.15	2.75	1	000
31252		A	NASAL ENDOSCOPY, POLYPECTOMY	3.14	3.55	0.38	7.07	1	000
31254		A	REVISION OF ETHMOID SINUS	4.76	6.76	0.73	12.25	1	000
31255		A	REMOVAL OF ETHMOID SINUS	7.33	11.14	1.20	19.67	1	000
31256		A	EXPLORATION MAXILLARY SINUS	3.47	3.97	0.43	7.87	1	000
31258		A	NASAL ENDOSCOPY, SURGICAL	2.43	2.11	0.21	4.75	1	000
31260		A	ENDOSCOPY, MAXILLARY SINUS	2.29	2.95	0.33	5.57	1	000
31263		A	ENDOSCOPY, MAXILLARY SINUS	4.37	3.79	0.45	8.61	1	000
31265		A	ENDOSCOPY, MAXILLARY SINUS	3.15	6.65	0.73	10.53	1	000
31267		A	ENDOSCOPY, MAXILLARY SINUS	3.24	7.79	0.85	11.88	1	000
31268		A	ENDOSCOPY, MAXILLARY SINUS	3.36	2.86	0.27	6.49	1	000
31270		A	ENDOSCOPY, SPHENOID SINUS	2.79	1.01	0.10	3.90	1	000
31275		A	SPHENOID ENDOSCOPY, SURGICAL	3.90	6.39	0.69	10.98	1	000
31277		A	SPHENOID ENDOSCOPY, SURGICAL	4.34	7.52	0.82	12.68	1	000
31285		A	ENDOSCOPY, COMBINED SINUSES	3.98	3.32	0.17	7.47	2	000
31299		C	SINUS SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
31300		A	REMOVAL OF LARYNX LESION	6.90	12.20	1.35	20.45	2	090
31320		A	DIAGNOSTIC INCISION LARYNX	4.78	4.07	0.51	9.36	2	090
31360		A	REMOVAL OF LARYNX	16.01	20.41	2.30	38.72	2	090
31365		A	REMOVAL OF LARYNX	20.17	28.60	3.26	52.03	2	090
31367		A	PARTIAL REMOVAL OF LARYNX	16.98	18.14	1.98	37.10	2	090
31368		A	PARTIAL REMOVAL OF LARYNX	21.23	28.21	3.22	52.66	2	090
31370		A	PARTIAL REMOVAL OF LARYNX	16.98	18.10	1.97	37.05	2	090
31375		A	PARTIAL REMOVAL OF LARYNX	16.98	15.63	1.65	34.26	2	090
31380		A	PARTIAL REMOVAL OF LARYNX	16.98	18.20	1.97	37.15	2	090
31382		A	PARTIAL REMOVAL OF LARYNX	16.98	16.92	1.87	35.77	2	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
31390		A	REMOVAL OF LARYNX & PHARYNX	22.29	36.72	4.27	63.28	2	090
31395		A	RECONSTRUCT LARYNX & PHARYNX	27.60	39.54	4.66	71.80	2	090
31400		A	REVISION OF LARYNX	9.55	8.23	0.96	18.74	2	090
31420		A	REMOVAL OF EPIGLOTTIS	9.55	8.52	0.88	18.95	2	090
31500		A	INSERT OF EMERGENCY AIRWAY	2.46	1.20	0.14	3.80	2	000
31502		A	CHANGE OF WINDPIPE AIRWAY	0.69	0.52	0.06	1.27	2	000
31505		A	DIAGNOSTIC LARYNGOSCOPY	0.65	0.45	0.05	1.15	1	000
31510		A	LARYNGOSCOPY WITH BIOPSY	2.03	0.59	0.07	2.69	1	000
31511		A	REMOVE FOREIGN BODY, LARYNX	2.27	1.01	0.10	3.38	1	000
31512		A	REMOVAL OF LARYNX LESION	2.18	1.88	0.21	4.27	1	000
31513		A	INJECTION INTO VOCAL CORD	2.21	3.64	0.39	6.24	1	000
31515		A	LARYNGOSCOPY FOR ASPIRATION	1.89	1.19	0.14	3.22	1	000
31520		A	DIAGNOSTIC LARYNGOSCOPY	2.69	1.73	0.19	4.61	1	000
31525		A	DIAGNOSTIC LARYNGOSCOPY	2.48	2.31	0.24	5.03	1	000
31526		A	DIAGNOSTIC LARYNGOSCOPY	2.71	3.67	0.39	6.77	1	000
31527		A	LARYNGOSCOPY FOR TREATMENT	3.45	3.15	0.31	6.91	1	000
31528		A	LARYNGOSCOPY AND DILATATION	2.50	2.81	0.31	5.62	1	000
31529		A	LARYNGOSCOPY AND DILATATION	2.83	2.59	0.26	5.68	1	000
31530		A	OPERATIVE LARYNGOSCOPY	3.58	3.83	0.41	7.82	1	000
31531		A	OPERATIVE LARYNGOSCOPY	3.93	5.91	0.64	10.48	1	000
31535		A	OPERATIVE LARYNGOSCOPY	3.33	4.22	0.47	8.02	1	000
31536		A	OPERATIVE LARYNGOSCOPY	3.34	5.87	0.63	9.84	1	000
31540		A	OPERATIVE LARYNGOSCOPY	4.35	5.89	0.65	10.89	1	000
31541		A	OPERATIVE LARYNGOSCOPY	3.75	7.31	0.79	11.85	1	000
31560		A	OPERATIVE LARYNGOSCOPY	5.75	5.27	0.55	11.57	1	000
31561		A	OPERATIVE LARYNGOSCOPY	5.16	10.61	1.13	16.90	1	000
31570		A	LARYNGOSCOPY WITH INJECTION	4.07	6.06	0.64	10.77	1	000
31571		A	LARYNGOSCOPY WITH INJECTION	3.71	6.78	0.73	11.22	1	000
31575		A	DIAGNOSTIC LARYNGOSCOPY	1.15	1.65	0.17	2.97	1	000
31576		A	LARYNGOSCOPY WITH BIOPSY	2.08	3.18	0.34	5.60	1	000
31577		A	REMOVE FOREIGN BODY, LARYNX	2.60	3.87	0.38	6.85	1	000
31578		A	REMOVAL OF LARYNX LESION	2.99	4.87	0.51	8.37	1	000
31579		A	DIAGNOSTIC LARYNGOSCOPY	2.39	2.46	0.27	5.12	1	000
31580		A	REVISION OF LARYNX	11.60	10.40	1.15	23.15	1	090
31582		C	REVISION OF LARYNX	0.00	0.00	0.00	0.00		090
31584		A	REPAIR OF LARYNX FRACTURE	14.62	13.40	1.41	29.43	1	090
31585		A	REPAIR OF LARYNX FRACTURE	4.64	3.97	0.42	9.03	1	090
31586		A	REPAIR OF LARYNX FRACTURE	7.63	6.90	0.75	15.28	1	090
31587		A	REVISION OF LARYNX	8.41	7.60	0.83	16.84	1	090
31588		C	REVISION OF LARYNX	0.00	0.00	0.00	0.00		090
31590		C	REINNERVATE LARYNX	0.00	0.00	0.00	0.00		090
31595		A	LARYNX NERVE SURGERY	7.98	7.21	0.78	15.97	1	090
31599		C	LARYNX SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
31600		A	INCISION OF WINDPIPE	4.78	4.25	0.69	9.72	2	090
31601		A	INCISION OF WINDPIPE	5.31	5.31	0.70	11.32	2	090
31603		A	INCISION OF WINDPIPE	4.38	4.46	0.70	9.54	2	000
31605		A	INCISION OF WINDPIPE	3.77	4.42	0.54	8.73	2	000
31610		A	INCISION OF WINDPIPE	8.29	7.03	0.97	16.29	1	090
31611		A	SURGERY/SPEECH PROSTHESIS	5.31	4.80	0.52	10.63	2	090
31612		A	PUNCTURE/CLEAR WINDPIPE	0.96	1.23	0.12	2.31	2	000
31613		A	REPAIR WINDPIPE OPENING	4.47	2.32	0.29	7.08	1	090
31614		A	REPAIR WINDPIPE OPENING	6.44	7.10	0.77	14.31	1	090
31615		A	VISUALIZATION OF WINDPIPE	2.20	2.06	0.23	4.49	1	000
31622		A	DIAGNOSTIC BRONCHOSCOPY	2.95	3.76	0.35	7.06	1	000
31625		A	BRONCHOSCOPY WITH BIOPSY	3.55	4.03	0.36	7.94	1	000
31628		A	BRONCHOSCOPY WITH BIOPSY	4.01	5.44	0.39	9.84	2	000
31629		A	BRONCHOSCOPY WITH BIOPSY	3.55	4.75	0.35	8.65	2	000
31630		A	BRONCHOSCOPY WITH REPAIR	4.02	3.92	0.53	8.47	1	000
31631		A	BRONCHOSCOPY WITH DILATION	4.61	4.15	0.51	9.27	1	000
31635		A	REMOVE FOREIGN BODY, AIRWAY	3.88	4.77	0.57	9.22	1	000
31640		A	BRONCHOSCOPY & REMOVE LESION	5.20	5.30	0.71	11.21	1	000
31641		A	BRONCHOSCOPY, TREAT BLOCKAGE	5.31	8.38	0.90	14.59	1	000
31645		A	BRONCHOSCOPY, CLEAR AIRWAYS	3.33	3.82	0.31	7.46	1	000
31646		A	BRONCHOSCOPY, RECLEAR AIRWAYS	2.87	3.22	0.28	6.37	1	000
31656		A	BRONCHOSCOPY, INJECT FOR XRAY	2.28	3.57	0.32	6.17	1	000
31659		A	BRONCHOSCOPIC PROCEDURES	2.77	2.10	0.25	5.12	1	000
31700		A	INSERTION OF AIRWAY CATHETER	1.41	1.00	0.17	2.58	1	000
31708		A	INSTILL AIRWAY CONTRAST DYE	1.49	0.81	0.09	2.39	1	ZZZ

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
31710		A	INSERTION OF AIRWAY CATHETER	1.37	0.95	0.12	2.44	1	000
31715		A	INJECTION FOR BRONCHUS X-RAY	1.16	0.90	0.08	2.14	1	222
31717		A	BRONCHIAL BRUSH BIOPSY	2.23	0.77	0.06	3.06	1	000
31719		A	INSERT WINDPIPE TUBE	1.49	2.60	0.24	4.33	1	000
31720		A	CLEARANCE OF AIRWAYS	1.11	0.78	0.09	1.98	1	000
31725		A	CLEARANCE OF AIRWAYS	2.07	1.49	0.15	3.71	1	000
31750		A	REPAIR OF WINDPIPE	9.54	9.36	1.14	20.04	1	090
31755		C	REPAIR OF WINDPIPE	0.00	0.00	0.00	0.00		090
31760		A	REPAIR OF WINDPIPE	22.01	11.51	2.68	36.20	1	090
31766		A	RECONSTRUCTION OF WINDPIPE	21.23	19.39	1.17	41.79	2	090
31770		A	REPAIR/GRAFT OF BRONCHUS	22.29	15.88	2.19	40.36	2	090
31775		A	RECONSTRUCT BRONCHUS	23.35	17.25	2.03	42.63	2	090
31780		A	RECONSTRUCT WINDPIPE	13.18	18.26	2.19	33.63	1	090
31781		A	RECONSTRUCT WINDPIPE	17.41	12.38	2.21	32.00	1	090
31785		A	REMOVE WINDPIPE LESION	13.53	9.40	1.23	24.16	1	090
31786		A	REMOVE WINDPIPE LESION	19.11	14.02	2.36	35.49	2	090
31800		A	REPAIR OF WINDPIPE INJURY	7.14	5.16	0.80	13.10	2	090
31805		A	REPAIR OF WINDPIPE INJURY	13.27	10.35	1.49	25.11	2	090
31820		A	CLOSURE OF WINDPIPE LESION	4.32	3.78	0.49	8.59	1	090
31825		A	REPAIR OF WINDPIPE DEFECT	6.64	5.28	0.62	12.54	1	090
31830		A	REVISE WINDPIPE SCAR	4.50	3.86	0.44	8.80	1	090
31899		C	AIRWAYS SURGICAL PROCEDURE	0.00	0.00	0.00	0.00		YYY
32000		A	DRAINAGE OF CHEST	1.63	0.95	0.08	2.66	2	000
32002		A	TREATMENT OF COLLAPSED LUNG	2.56	1.41	0.23	4.20	2	010
32005		A	TREAT LUNG LINING CHEMICALLY	2.56	1.14	0.15	3.85	2	010
32020		A	INSERTION OF CHEST TUBE	4.66	2.77	0.45	7.88	1	010
32035		A	EXPLORATION OF CHEST	6.90	7.13	1.32	15.35	2	090
32036		A	EXPLORATION OF CHEST	7.96	7.52	1.39	16.87	2	090
32095		A	BIOPSY THROUGH CHEST WALL	7.51	8.69	1.53	17.73	1	090
32100		A	EXPLORATION/BIOPSY OF CHEST	10.61	11.84	2.21	24.66	1	090
32110		A	EXPLORE/REPAIR CHEST	12.40	12.13	2.12	26.65	1	090
32120		A	RE-EXPLORATION OF CHEST	10.14	9.97	1.81	21.92	1	090
32124		A	EXPLORE CHEST, FREE ADHESIONS	11.52	11.53	2.32	25.37	1	090
32140		A	REMOVAL OF LUNG LESION(S)	12.80	13.03	2.55	28.38	1	090
32141		A	REMOVE/TREAT LUNG LESIONS	12.80	14.14	2.66	29.60	2	090
32150		A	REMOVAL OF LUNG LESION(S)	13.09	10.90	2.12	26.11	1	090
32151		A	REMOVE LUNG FOREIGN BODY	13.09	9.64	1.45	24.18	2	090
32160		A	OPEN CHEST HEART MASSAGE	7.51	10.59	1.60	19.70	2	090
32200		A	DRAINAGE OF LUNG LESION	13.80	7.26	0.98	22.04	2	090
32215		A	TREAT CHEST LINING	10.61	8.02	1.35	19.98	2	090
32220		A	RELEASE OF LUNG	18.57	16.66	3.17	38.40	2	090
32225		A	PARTIAL RELEASE OF LUNG	12.74	12.48	2.41	27.63	2	090
32310		A	REMOVAL OF CHEST LINING	12.74	14.08	2.49	29.31	2	090
32315		A	PARTIAL REMOVAL CHEST LINING	12.58	8.55	1.68	22.81	1	090
32320		A	FREE/REMOVE CHEST LINING	20.17	19.07	3.59	42.83	2	090
32400		A	NEEDLE BIOPSY CHEST LINING	1.85	1.56	0.12	3.53	2	000
32402		A	OPEN BIOPSY CHEST LINING	6.90	7.98	1.41	16.29	2	090
32405		A	BIOPSY, LUNG OR MEDIASTINUM	2.04	2.23	0.19	4.46	2	000
32420		A	PUNCTURE/CLEAR LUNG	2.29	1.58	0.13	4.00	2	000
32440		A	REMOVAL OF LUNG	20.17	19.56	3.74	43.47	2	090
32445		A	REMOVAL OF LUNG	24.63	21.56	4.08	50.27	1	090
32450		A	REMOVAL OF LUNG	26.00	18.97	3.55	48.52	2	090
32480		A	PARTIAL REMOVAL OF LUNG	18.36	18.07	3.40	39.83	1	090
32485		A	PARTIAL REMOVAL OF LUNG	22.69	22.62	4.14	49.45	1	090
32490		A	PARTIAL REMOVAL OF LUNG	23.22	23.90	4.45	51.57	2	090
32500		A	PARTIAL REMOVAL OF LUNG	13.80	14.20	2.69	30.69	2	090
32520		A	REMOVE LUNG & REVISE CHEST	20.47	21.79	4.13	46.39	1	090
32522		A	REMOVE LUNG & REVISE CHEST	23.11	23.07	4.42	50.60	1	090
32525		A	REMOVE LUNG & REVISE CHEST	25.63	24.76	4.86	55.25	1	090
32540		A	REMOVAL OF LUNG LESION	15.60	13.48	2.53	31.61	1	090
32545		A	REMOVAL OF LUNG LOBE/LESION	21.23	13.68	2.84	37.75	2	090
32700		A	VISUALIZE CHEST CAVITY	5.75	3.66	0.61	10.02	1	090
32705		A	INSPECT/BIOPSY CHEST CAVITY	6.28	4.07	0.68	11.03	2	090
32800		A	REPAIR LUNG HERNIA	12.74	8.72	1.67	23.13	2	090
32810		A	CLOSE CHEST AFTER DRAINAGE	12.21	6.85	1.25	20.31	2	090
32815		A	CLOSE BRONCHIAL FISTULA	22.51	16.04	2.76	41.31	1	090
32820		C	RECONSTRUCT INJURED CHEST	0.00	0.00	0.00	0.00		090
32900		A	REMOVAL OF RIB(S)	19.11	8.92	1.72	29.75	2	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPs*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
32905		A	REVISE & REPAIR CHEST WALL	20.17	13.42	2.74	36.33	2	090
32906		A	REVISE & REPAIR CHEST WALL	26.53	16.25	3.08	45.86	2	090
32940		A	REVISION OF LUNG	19.11	11.98	1.84	32.93	2	090
32960		A	THERAPEUTIC PNEUMOTHORAX	1.93	0.98	0.13	3.04	2	000
32999		C	CHEST SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
33010		A	DRAINAGE OF HEART SAC	2.36	1.63	0.14	4.13	1	000
33011		A	REPEAT DRAINAGE OF HEART SAC	2.36	1.16	0.12	3.64	2	000
33015		A	INCISION OF HEART SAC	4.10	4.50	0.66	9.26	1	090
33020		A	INCISION OF HEART SAC	11.68	13.98	2.65	28.31	2	090
33025		A	INCISION OF HEART SAC	8.82	14.74	2.75	26.31	1	090
33030		A	PARTIAL REMOVAL OF HEART SAC	17.51	23.29	4.53	45.33	2	090
33031		A	PARTIAL REMOVAL OF HEART SAC	20.70	14.14	2.41	37.25	2	090
33050		A	REMOVAL OF HEART SAC LESION	13.38	9.74	1.55	24.67	1	090
33100		A	REMOVAL OF HEART SAC	17.51	21.00	3.75	42.26	2	090
33120		A	REMOVAL OF HEART LESION	23.78	31.10	5.45	60.33	1	090
33130		A	REMOVAL OF HEART LESION	20.58	14.23	2.33	37.14	1	090
33200		A	INSERTION OF HEART PACEMAKER	10.43	12.93	2.01	25.37	1	090
33201		A	INSERTION OF HEART PACEMAKER	9.41	11.79	1.76	22.96	1	090
33206		A	INSERTION OF HEART PACEMAKER	6.37	9.36	1.41	17.14	1	090
33207		A	INSERTION OF HEART PACEMAKER	7.67	9.49	1.40	18.56	1	090
33208		A	INSERTION OF HEART PACEMAKER	7.83	12.12	1.63	21.58	1	090
33210		A	INSERTION OF HEART ELECTRODE	3.49	3.48	0.28	7.25	2	000
33212		A	INSERTION OF PULSE GENERATOR	6.33	5.67	0.93	12.93	1	090
33216		A	REVISION IMPLANTED ELECTRODE	5.58	5.30	0.59	11.47	1	090
33218		A	REPAIR PACEMAKER ELECTRODES	5.35	4.83	0.66	10.84	1	090
33219		A	REPAIR OF PACEMAKER	5.00	6.04	0.95	11.99	1	090
33222		A	PACEMAKER AICD POCKET	5.00	6.01	1.06	12.07	2	090
33232		A	REMOVAL OF PACEMAKER	5.16	4.19	0.66	10.01	1	090
33245		A	IMPLANT HEART DEFIBRILLATOR	16.26	17.62	2.49	36.37	1	090
33246		A	IMPLANT HEART DEFIBRILLATOR	20.32	21.91	3.36	45.59	1	090
33248		A	REVISE/REMOVE DEFIBRILLATOR	17.32	9.50	1.63	28.45	2	090
33250		A	ABLATE HEART DYSRHYTHM FOCUS	20.59	12.18	0.91	33.68	2	090
33251		A	ABLATE HEART DYSRHYTHM FOCUS	23.78	17.29	3.38	44.45	2	090
33260		A	ABLATE HEART DYSRHYTHM FOCUS	17.07	12.41	2.42	31.90	2	090
33261		A	ABLATE HEART DYSRHYTHM FOCUS	20.25	14.72	2.88	37.85	2	090
33300		A	REPAIR OF HEART WOUND	17.07	15.13	2.74	34.94	1	090
33305		A	REPAIR OF HEART WOUND	20.25	14.73	2.60	37.58	2	090
33310		A	EXPLORATORY HEART SURGERY	18.04	11.89	2.04	31.97	2	090
33315		A	EXPLORATORY HEART SURGERY	21.23	15.25	2.71	39.19	2	090
33320		A	REPAIR MAJOR BLOOD VESSEL(S)	16.21	14.90	2.64	33.75	2	090
33322		A	REPAIR MAJOR BLOOD VESSEL(S)	19.39	13.43	2.28	35.10	2	090
33330		A	INSERT MAJOR VESSEL GRAFT	20.17	13.35	2.04	35.56	2	090
33335		A	INSERT MAJOR VESSEL GRAFT	23.35	15.88	2.52	41.75	2	090
33350		C	REPAIR MAJOR BLOOD VESSEL(S)	0.00	0.00	0.00	0.00		090
33400		A	REPAIR OF AORTIC VALVE	24.41	27.62	2.98	55.01	2	090
33404		A	PREPARE HEART-AORTA CONDUIT	28.05	20.40	3.98	52.43	1	090
33405		A	REPLACEMENT OF AORTIC VALVE	25.84	32.12	5.62	63.58	2	090
33407		C	REVISION OF AORTIC VALVE	0.00	0.00	0.00	0.00		090
33408		C	REVISION OF AORTIC VALVE	0.00	0.00	0.00	0.00		090
33411		A	REPLACEMENT OF AORTIC VALVE	26.41	40.72	7.85	74.98	2	090
33412		C	REPLACEMENT OF AORTIC VALVE	0.00	0.00	0.00	0.00		090
33415		C	REVISION, SUBVALVULAR TISSUE	0.00	0.00	0.00	0.00		090
33416		A	REVISE VENTRICLE MUSCLE	29.72	21.61	4.22	55.55	2	090
33417		C	REPAIR OF AORTIC VALVE	0.00	0.00	0.00	0.00		090
33420		A	REVISION OF MITRAL VALVE	21.81	20.88	2.58	45.27	1	090
33422		A	REVISION OF MITRAL VALVE	25.00	36.37	6.80	68.17	2	090
33425		A	REPAIR OF MITRAL VALVE	26.94	32.96	5.71	65.61	2	090
33426		A	REPAIR OF MITRAL VALVE	27.47	19.97	3.90	51.34	2	090
33427		A	REPAIR OF MITRAL VALVE	29.72	21.61	4.22	55.55	2	090
33430		A	REPLACEMENT OF MITRAL VALVE	26.53	36.72	6.44	69.69	2	090
33452		A	REVISION OF TRICUSPID VALVE	21.81	15.40	2.48	39.69	2	090
33460		A	REVISION OF TRICUSPID VALVE	24.82	27.47	4.98	57.27	2	090
33465		A	REPLACE TRICUSPID VALVE	24.94	34.42	6.27	65.63	2	090
33468		A	REVISION OF TRICUSPID VALVE	29.72	21.04	3.81	54.57	2	090
33470		C	REVISION OF PULMONARY VALVE	0.00	0.00	0.00	0.00		090
33471		D	REVISION OF PULMONARY VALVE	0.00	0.00	0.00	0.00		XXX
33472		C	REVISION OF PULMONARY VALVE	0.00	0.00	0.00	0.00		090
33474		A	REVISION OF PULMONARY VALVE	22.03	14.06	1.71	37.80	2	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
33476		C	REVISION OF HEART CHAMBER	0.00	0.00	0.00	0.00		090
33478		C	REVISION OF HEART CHAMBER	0.00	0.00	0.00	0.00		090
33480		D	REVISION OF HEART VALVES	0.00	0.00	0.00	0.00		XXX
33481		D	REVISION OF HEART VALVES	0.00	0.00	0.00	0.00		XXX
33482		D	REVISION OF HEART VALVES	0.00	0.00	0.00	0.00		XXX
33483		D	REPLACEMENT OF HEART VALVES	0.00	0.00	0.00	0.00		XXX
33485		D	REPLACEMENT OF HEART VALVES	0.00	0.00	0.00	0.00		XXX
33490		D	REVISION OF HEART VALVES	0.00	0.00	0.00	0.00		XXX
33492		D	REPLACEMENT OF HEART VALVES	0.00	0.00	0.00	0.00		XXX
33500		A	REPAIR HEART VESSEL FISTULA	22.27	16.19	3.16	41.62	1	090
33502		A	CORONARY ARTERY CORRECTION	20.86	14.01	1.95	36.82	1	090
33503		A	CORONARY ARTERY GRAFT	21.23	14.34	1.05	36.62	2	090
33504		A	CORONARY ARTERY GRAFT	24.41	14.18	2.75	41.34	2	090
33510		A	CORONARY ARTERY BYPASS	23.67	29.26	5.15	58.08	2	090
33511		A	CORONARY ARTERIES BYPASS	25.03	35.36	6.25	66.64	2	090
33512		A	CORONARY ARTERIES BYPASS	26.41	38.61	6.76	71.78	2	090
33513		A	CORONARY ARTERIES BYPASS	27.79	41.27	7.31	76.37	2	090
33514		A	CORONARY ARTERIES BYPASS	29.17	42.27	7.43	78.87	2	090
33516		A	CORONARY ARTERIES BYPASS	30.55	42.57	7.51	80.63	2	090
33520		D	CORONARY ARTERY, BYPASS/GRAFT	0.00	0.00	0.00	0.00		XXX
33525		D	CORONARY ARTERY, BYPASS/GRAFT	0.00	0.00	0.00	0.00		XXX
33528		D	CORONARY ARTERY, BYPASS/GRAFT	0.00	0.00	0.00	0.00		XXX
33530		A	CORONARY ARTERY, BYPASS/REOP	6.18	4.49	0.88	11.55	1	222
33542		A	REMOVAL OF HEART LESION	24.14	32.38	5.82	62.34	1	090
33545		A	REPAIR OF HEART DAMAGE	29.72	36.80	6.61	73.13	2	090
33570		A	REVISE CORONARY CIRCULATION	18.36	14.80	2.44	35.60	2	090
33575		C	REVISE CORONARY CIRCULATION	0.00	0.00	0.00	0.00		090
33641		C	REPAIR HEART SEPTUM DEFECT	0.00	0.00	0.00	0.00		090
33645		C	REVISION OF HEART VEINS	0.00	0.00	0.00	0.00		090
33647		C	REPAIR HEART SEPTUM DEFECTS	0.00	0.00	0.00	0.00		090
33649		C	REPAIR TRICUSPID DEFECT	0.00	0.00	0.00	0.00		090
33660		C	REPAIR OF HEART DEFECTS	0.00	0.00	0.00	0.00		090
33665		C	REPAIR OF HEART DEFECTS	0.00	0.00	0.00	0.00		090
33670		C	REPAIR OF HEART CHAMBERS	0.00	0.00	0.00	0.00		090
33681		C	REPAIR HEART SEPTUM DEFECT	0.00	0.00	0.00	0.00		090
33684		C	REPAIR HEART SEPTUM DEFECT	0.00	0.00	0.00	0.00		090
33688		C	REPAIR HEART SEPTUM DEFECT	0.00	0.00	0.00	0.00		090
33690		C	REINFORCE PULMONARY ARTERY	0.00	0.00	0.00	0.00		090
33692		C	REPAIR OF HEART DEFECTS	0.00	0.00	0.00	0.00		090
33694		C	REPAIR OF HEART DEFECTS	0.00	0.00	0.00	0.00		090
33696		C	REPAIR OF HEART DEFECTS	0.00	0.00	0.00	0.00		090
33702		C	REPAIR OF HEART DEFECTS	0.00	0.00	0.00	0.00		090
33710		C	REPAIR OF HEART DEFECTS	0.00	0.00	0.00	0.00		090
33720		C	REPAIR OF HEART DEFECT	0.00	0.00	0.00	0.00		090
33730		C	REPAIR HEART-VEIN DEFECT(S)	0.00	0.00	0.00	0.00		090
33735		C	REVISION OF HEART CHAMBER	0.00	0.00	0.00	0.00		090
33737		C	REVISION OF HEART CHAMBER	0.00	0.00	0.00	0.00		090
33738		C	REVISION OF HEART CHAMBER	0.00	0.00	0.00	0.00		090
33739		C	REVISION OF HEART CHAMBER	0.00	0.00	0.00	0.00		090
33750		C	MAJOR VESSEL SHUNT	0.00	0.00	0.00	0.00		090
33755		C	MAJOR VESSEL SHUNT	0.00	0.00	0.00	0.00		090
33762		C	MAJOR VESSEL SHUNT	0.00	0.00	0.00	0.00		090
33764		C	MAJOR VESSEL SHUNT & GRAFT	0.00	0.00	0.00	0.00		090
33766		C	MAJOR VESSEL SHUNT	0.00	0.00	0.00	0.00		090
33774		C	REPAIR GREAT VESSELS DEFECT	0.00	0.00	0.00	0.00		090
33775		C	REPAIR GREAT VESSELS DEFECT	0.00	0.00	0.00	0.00		090
33776		C	REPAIR GREAT VESSELS DEFECT	0.00	0.00	0.00	0.00		090
33777		C	REPAIR GREAT VESSELS DEFECT	0.00	0.00	0.00	0.00		090
33778		C	REPAIR GREAT VESSELS DEFECT	0.00	0.00	0.00	0.00		090
33779		C	REPAIR GREAT VESSELS DEFECT	0.00	0.00	0.00	0.00		090
33780		C	REPAIR GREAT VESSELS DEFECT	0.00	0.00	0.00	0.00		090
33781		C	REPAIR GREAT VESSELS DEFECT	0.00	0.00	0.00	0.00		090
33786		C	REPAIR ARTERIAL TRUNK	0.00	0.00	0.00	0.00		090
33788		C	REVISION OF PULMONARY ARTERY	0.00	0.00	0.00	0.00		090
33802		C	REPAIR VESSEL DEFECT	0.00	0.00	0.00	0.00		090
33803		C	REPAIR VESSEL DEFECT	0.00	0.00	0.00	0.00		090
33813		C	REPAIR SEPTAL DEFECT	0.00	0.00	0.00	0.00		090
33814		C	REPAIR SEPTAL DEFECT	0.00	0.00	0.00	0.00		090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
33820		C	REVISE MAJOR VESSEL	0.00	0.00	0.00	0.00		090
33822		C	REVISE MAJOR VESSEL	0.00	0.00	0.00	0.00		090
33824		C	REVISE MAJOR VESSEL	0.00	0.00	0.00	0.00		090
33830		C	REVISE MAJOR VESSEL	0.00	0.00	0.00	0.00		090
33840		C	REMOVE AORTA CONSTRICTION	0.00	0.00	0.00	0.00		090
33845		C	REMOVE AORTA CONSTRICTION	0.00	0.00	0.00	0.00		090
33851		C	REMOVE AORTA CONSTRICTION	0.00	0.00	0.00	0.00		090
33852		C	REPAIR SEPTAL DEFECT	0.00	0.00	0.00	0.00		090
33855		C	REPAIR SEPTAL DEFECT	0.00	0.00	0.00	0.00		090
33860		A	ASCENDING AORTA GRAFT	36.09	36.58	6.51	79.18	2	090
33865		A	ASCENDING AORTA GRAFT	38.21	54.96	9.47	102.64	2	090
33870		A	TRANSVERSE AORTIC ARCH GRAFT	39.77	46.68	8.48	94.93	1	090
33875		A	THORACIC AORTA GRAFT	28.39	32.94	5.88	67.21	1	090
33877		A	THORACOABDOMINAL GRAFT	42.46	46.48	8.83	97.77	2	090
33910		A	REMOVE LUNG ARTERY EMBOLI	23.03	15.43	2.92	41.38	2	090
33915		A	REMOVE LUNG ARTERY EMBOLI	19.85	12.66	2.33	34.84	2	090
33916		A	SURGERY OF GREAT VESSEL	25.47	18.52	3.62	47.61	2	090
33930		E	REMOVAL OF DONOR HEART/LUNG	0.00	0.00	0.00	0.00		XXX
33935		C	TRANSPLANTATION, HEART/LUNG	0.00	0.00	0.00	0.00		090
33940		E	REMOVAL OF DONOR HEART	0.00	0.00	0.00	0.00		XXX
33945		C	TRANSPLANTATION OF HEART	0.00	0.00	0.00	0.00		090
33960		C	EXTERNAL CIRCULATION ASSIST	0.00	0.00	0.00	0.00		222
33970		A	AORTIC CIRCULATION ASSIST	8.49	7.94	1.05	17.48	2	000
33971		A	AORTIC CIRCULATION ASSIST	4.25	5.85	0.96	11.06	2	090
33972		A	AORTIC CIRCULATION ASSIST	2.14	0.67	0.07	2.88	2	222
33999		C	CARDIAC SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
34001		A	REMOVAL OF ARTERY CLOT	12.32	10.10	1.96	24.38	1	090
34051		A	REMOVAL OF ARTERY CLOT	14.35	9.29	1.68	25.32	1	090
34101		A	REMOVAL OF ARTERY CLOT	9.21	8.78	1.80	19.79	1	090
34111		A	REMOVAL OF ARM ARTERY CLOT	7.57	7.99	1.68	17.24	1	090
34151		A	REMOVAL OF ARTERY CLOT	13.86	12.60	2.52	28.98	1	090
34201		A	REMOVAL OF ARTERY CLOT	9.75	9.38	1.87	21.00	1	090
34203		A	REMOVAL OF LEG ARTERY CLOT	11.65	9.10	1.81	22.56	1	090
34401		A	REMOVAL OF VEIN CLOT	12.26	8.51	1.47	22.24	1	090
34421		A	REMOVAL OF VEIN CLOT	9.37	7.85	1.59	18.81	1	090
34451		A	REMOVAL OF VEIN CLOT	13.83	11.26	2.25	27.34	1	090
34471		A	REMOVAL OF VEIN CLOT	9.61	3.70	0.59	13.90	1	090
34490		A	REMOVAL OF VEIN CLOT	6.86	7.66	1.63	16.15	1	090
34501		C	REPAIR VALVE, FEMORAL VEIN	0.00	0.00	0.00	0.00		090
34510		C	TRANSPOSITION OF VEIN VALVE	0.00	0.00	0.00	0.00		090
34520		C	CROSS-OVER VEIN GRAFT	0.00	0.00	0.00	0.00		090
34530		C	LEG VEIN FUSION	0.00	0.00	0.00	0.00		090
35001		A	REPAIR DEFECT OF ARTERY	17.07	16.76	3.35	37.18	1	090
35002		A	REPAIR ARTERY RUPTURE, NECK	20.48	13.32	2.54	36.34	2	090
35005		A	REPAIR DEFECT OF ARTERY	17.51	10.83	2.30	30.64	2	090
35011		A	REPAIR DEFECT OF ARTERY	14.02	14.22	2.91	31.15	1	090
35013		A	REPAIR ARTERY RUPTURE, ARM	16.82	15.49	3.19	35.50	2	090
35021		A	REPAIR DEFECT OF ARTERY	18.57	19.10	3.22	40.89	2	090
35022		A	REPAIR ARTERY RUPTURE, CHEST	22.29	15.57	2.95	40.81	2	090
35045		A	REPAIR DEFECT OF ARM ARTERY	10.51	13.01	2.63	26.15	1	090
35081		A	REPAIR DEFECT OF ARTERY	23.35	22.61	4.41	50.37	2	090
35082		A	REPAIR ARTERY RUPTURE, AORTA	30.36	24.13	4.83	59.32	2	090
35091		A	REPAIR DEFECT OF ARTERY	26.00	23.88	4.48	54.36	2	090
35092		A	REPAIR ARTERY RUPTURE, AORTA	33.81	27.68	5.49	66.98	2	090
35102		A	REPAIR DEFECT OF ARTERY	23.88	23.34	4.56	51.78	2	090
35103		A	REPAIR ARTERY RUPTURE, GROIN	31.05	27.57	5.49	64.11	2	090
35111		A	REPAIR DEFECT OF ARTERY	15.93	18.55	3.90	38.38	1	090
35112		A	REPAIR ARTERY RUPTURE, SPLEEN	18.31	11.02	2.33	31.66	2	090
35121		A	REPAIR DEFECT OF ARTERY	26.00	20.14	3.86	50.00	2	090
35122		A	REPAIR ARTERY RUPTURE, BELLY	33.81	18.89	4.17	56.87	2	090
35131		A	REPAIR DEFECT OF ARTERY	17.92	16.74	3.31	37.97	1	090
35132		A	REPAIR ARTERY RUPTURE, GROIN	21.50	19.69	3.78	44.97	2	090
35141		A	REPAIR DEFECT OF ARTERY	14.00	15.49	3.03	32.52	1	090
35142		A	REPAIR ARTERY RUPTURE, THIGH	15.40	16.96	3.42	35.78	2	090
35151		A	REPAIR DEFECT OF ARTERY	14.81	16.18	3.10	34.09	1	090
35152		A	REPAIR ARTERY RUPTURE, KNEE	16.29	9.76	2.06	28.11	2	090
35161		C	REPAIR DEFECT OF ARTERY	0.00	0.00	0.00	0.00		090
35162		C	REPAIR ARTERY RUPTURE	0.00	0.00	0.00	0.00		090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
35180		A	REPAIR BLOOD VESSEL LESION	12.82	7.77	1.56	22.15	1	090
35182		A	REPAIR BLOOD VESSEL LESION	16.98	11.22	1.70	29.90	2	090
35184		A	REPAIR BLOOD VESSEL LESION	11.37	10.26	2.07	23.70	1	090
35188		A	REPAIR BLOOD VESSEL LESION	13.80	8.55	1.68	24.03	2	090
35189		A	REPAIR BLOOD VESSEL LESION	18.04	11.94	2.32	32.30	2	090
35190		A	REPAIR BLOOD VESSEL LESION	12.43	10.90	2.25	25.58	2	090
35201		A	REPAIR BLOOD VESSEL LESION	9.38	10.61	2.05	22.04	1	090
35206		A	REPAIR BLOOD VESSEL LESION	8.94	10.70	2.14	21.78	1	090
35207		A	REPAIR BLOOD VESSEL LESION	9.55	11.38	2.04	22.97	2	090
35211		A	REPAIR BLOOD VESSEL LESION	21.23	14.10	2.73	38.06	2	090
35216		A	REPAIR BLOOD VESSEL LESION	18.04	11.25	2.19	31.48	2	090
35221		A	REPAIR BLOOD VESSEL LESION	15.92	11.69	2.31	29.92	2	090
35226		A	REPAIR BLOOD VESSEL LESION	8.61	10.83	2.06	21.50	1	090
35231		A	REPAIR BLOOD VESSEL LESION	11.34	16.89	3.07	31.30	1	090
35236		A	REPAIR BLOOD VESSEL LESION	9.88	13.56	2.70	26.14	1	090
35241		A	REPAIR BLOOD VESSEL LESION	22.29	14.22	2.74	39.25	2	090
35246		A	REPAIR BLOOD VESSEL LESION	19.11	17.87	2.26	39.24	2	090
35251		A	REPAIR BLOOD VESSEL LESION	16.98	10.11	1.98	29.07	2	090
35256		A	REPAIR BLOOD VESSEL LESION	10.69	13.07	2.52	26.28	1	090
35261		A	REPAIR BLOOD VESSEL LESION	10.96	13.88	2.81	27.65	1	090
35266		A	REPAIR BLOOD VESSEL LESION	9.55	12.33	2.54	24.42	2	090
35271		A	REPAIR BLOOD VESSEL LESION	21.23	13.21	2.70	37.14	2	090
35276		A	REPAIR BLOOD VESSEL LESION	18.04	11.43	2.39	31.86	2	090
35281		A	REPAIR BLOOD VESSEL LESION	15.92	18.21	3.55	37.68	2	090
35286		A	REPAIR BLOOD VESSEL LESION	11.36	12.34	2.46	26.16	1	090
35301		A	RECHANNELING OF ARTERY	17.07	15.23	2.96	35.26	2	090
35311		A	RECHANNELING OF ARTERY	18.57	23.25	4.85	46.67	2	090
35321		A	RECHANNELING OF ARTERY	11.68	13.65	2.84	28.17	2	090
35331		A	RECHANNELING OF ARTERY	23.35	14.06	2.81	40.22	2	090
35341		A	RECHANNELING OF ARTERY	24.94	18.30	3.72	46.96	2	090
35351		A	RECHANNELING OF ARTERY	20.17	15.76	3.13	39.06	2	090
35355		A	RECHANNELING OF ARTERY	15.92	16.25	3.15	35.32	2	090
35361		A	RECHANNELING OF ARTERY	23.35	20.42	4.08	47.85	2	090
35363		A	RECHANNELING OF ARTERY	24.41	23.99	4.64	53.04	2	090
35371		A	RECHANNELING OF ARTERY	11.06	13.19	2.63	26.88	1	090
35372		A	RECHANNELING OF ARTERY	12.94	11.80	2.41	27.15	1	090
35381		A	RECHANNELING OF ARTERY	13.80	14.40	2.86	31.06	2	090
35450		A	REPAIR ARTERIAL BLOCKAGE	10.61	14.15	1.46	26.22	2	222
35452		A	REPAIR ARTERIAL BLOCKAGE	7.28	4.59	0.65	12.52	2	222
35454		A	REPAIR ARTERIAL BLOCKAGE	6.37	9.79	1.62	17.78	2	222
35456		A	REPAIR ARTERIAL BLOCKAGE	7.75	10.96	1.78	20.49	2	222
35458		A	REPAIR ARTERIAL BLOCKAGE	10.01	10.67	1.92	22.60	2	222
35459		A	REPAIR ARTERIAL BLOCKAGE	9.10	4.76	1.11	14.97	2	000
35460		A	REPAIR VENOUS BLOCKAGE	6.37	3.33	0.78	10.48	2	000
35470		A	REPAIR ARTERIAL BLOCKAGE	9.10	4.76	1.11	14.97	2	000
35471		A	REPAIR ARTERIAL BLOCKAGE	10.61	5.55	1.29	17.45	2	000
35472		A	REPAIR ARTERIAL BLOCKAGE	7.28	3.81	0.89	11.98	2	000
35473		A	REPAIR ARTERIAL BLOCKAGE	6.37	3.33	0.78	10.48	2	000
35474		A	REPAIR ARTERIAL BLOCKAGE	7.76	4.06	0.94	12.76	2	000
35475		A	REPAIR ARTERIAL BLOCKAGE	10.01	5.23	1.22	16.46	2	000
35476		A	REPAIR VENOUS BLOCKAGE	6.37	3.33	0.78	10.48	2	000
35501		A	ARTERY BYPASS GRAFT	17.60	20.40	3.68	41.68	2	090
35506		A	ARTERY BYPASS GRAFT	17.60	20.20	3.84	41.64	2	090
35507		A	ARTERY BYPASS GRAFT	17.60	18.89	3.81	40.30	2	090
35508		A	ARTERY BYPASS GRAFT	18.13	10.11	2.23	30.47	2	090
35509		A	ARTERY BYPASS GRAFT	17.60	19.91	4.12	41.63	2	090
35511		A	ARTERY BYPASS GRAFT	16.22	10.97	2.03	29.22	2	090
35515		A	ARTERY BYPASS GRAFT	18.13	11.86	2.12	32.11	2	090
35516		A	ARTERY BYPASS GRAFT	15.69	18.30	3.73	37.72	2	090
35518		A	ARTERY BYPASS GRAFT	14.81	18.40	3.56	36.77	2	090
35521		A	ARTERY BYPASS GRAFT	20.17	18.47	3.52	42.16	2	090
35526		A	ARTERY BYPASS GRAFT	19.64	13.64	2.57	35.85	2	090
35531		A	ARTERY BYPASS GRAFT	25.47	21.34	4.10	50.91	2	090
35533		A	ARTERY BYPASS GRAFT	20.17	22.17	4.67	47.01	2	090
35536		A	ARTERY BYPASS GRAFT	22.82	22.52	4.40	49.74	2	090
35541		A	ARTERY BYPASS GRAFT	25.47	20.60	3.85	49.92	2	090
35546		A	ARTERY BYPASS GRAFT	25.47	22.54	4.49	52.50	2	090
35548		C	ARTERY BYPASS GRAFT	0.00	0.00	0.00	0.00		090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
35549		C	ARTERY BYPASS GRAFT	0.00	0.00	0.00	0.00		090
35551		A	ARTERY BYPASS GRAFT	26.53	20.28	4.07	50.88	2	090
35556		A	ARTERY BYPASS GRAFT	16.90	19.72	3.91	40.53	2	090
35558		A	ARTERY BYPASS GRAFT	13.51	17.67	3.40	34.58	2	090
35560		A	ARTERY BYPASS GRAFT	20.17	21.30	4.13	45.60	2	090
35563		A	ARTERY BYPASS GRAFT	14.57	8.76	1.79	25.12	2	090
35565		A	ARTERY BYPASS GRAFT	14.57	18.86	3.70	37.13	2	090
35566		A	ARTERY BYPASS GRAFT	16.30	21.72	4.30	42.32	1	090
35571		A	ARTERY BYPASS GRAFT	17.09	20.41	4.07	41.57	2	090
35582		A	VEIN BYPASS GRAFT	27.07	25.02	5.14	57.23	2	090
35583		A	VEIN BYPASS GRAFT	17.43	21.93	4.35	43.71	2	090
35585		A	VEIN BYPASS GRAFT	20.78	24.19	4.88	49.85	2	090
35587		A	VEIN BYPASS GRAFT	17.62	22.67	4.35	44.64	2	090
35601		A	ARTERY BYPASS GRAFT	17.07	19.84	3.51	40.42	2	090
35606		A	ARTERY BYPASS GRAFT	17.07	18.49	3.70	39.26	2	090
35612		A	ARTERY BYPASS GRAFT	15.16	17.65	3.48	36.29	1	090
35616		A	ARTERY BYPASS GRAFT	15.16	17.69	3.61	36.46	2	090
35621		A	ARTERY BYPASS GRAFT	13.95	20.12	4.00	38.07	1	090
35626		A	ARTERY BYPASS GRAFT	18.57	21.61	4.30	44.48	2	090
35631		A	ARTERY BYPASS GRAFT	24.41	18.83	3.76	47.00	2	090
35636		A	ARTERY BYPASS GRAFT	22.29	14.23	2.58	39.10	2	090
35637		A	ARTERY BYPASS GRAFT	17.60	10.46	2.12	30.18	2	090
35638		A	ARTERY BYPASS GRAFT	14.77	9.91	2.02	26.70	2	090
35641		A	ARTERY BYPASS GRAFT	23.88	21.66	4.30	49.84	2	090
35642		A	ARTERY BYPASS GRAFT	17.60	10.88	2.31	30.79	2	090
35645		A	ARTERY BYPASS GRAFT	17.07	11.75	2.16	30.98	2	090
35646		A	ARTERY BYPASS GRAFT	23.88	25.06	4.98	53.92	2	090
35650		A	ARTERY BYPASS GRAFT	13.75	18.14	3.75	35.64	1	090
35651		A	ARTERY BYPASS GRAFT	24.94	25.39	4.94	55.27	2	090
35654		A	ARTERY BYPASS GRAFT	18.57	23.29	4.66	46.52	2	090
35656		A	ARTERY BYPASS GRAFT	15.31	19.01	3.80	38.12	1	090
35661		A	ARTERY BYPASS GRAFT	12.45	17.58	3.48	33.51	1	090
35663		A	ARTERY BYPASS GRAFT	13.51	19.25	4.00	36.76	2	090
35665		A	ARTERY BYPASS GRAFT	13.51	18.75	3.76	36.02	2	090
35666		A	ARTERY BYPASS GRAFT	18.66	21.14	4.21	44.01	1	090
35671		A	ARTERY BYPASS GRAFT	16.03	22.17	4.30	42.50	1	090
35681		A	ARTERY BYPASS GRAFT	8.49	18.45	3.71	30.65	2	ZZZ
35701		A	EXPLORATION, CAROTID ARTERY	4.78	7.16	1.32	13.26	2	090
35721		A	EXPLORATION, FEMORAL ARTERY	4.78	5.85	1.16	11.79	2	090
35741		A	EXPLORATION POPLITEAL ARTERY	4.78	6.04	1.21	12.03	2	090
35761		A	EXPLORATION OF ARTERY/VEIN	4.78	6.12	1.20	12.10	2	090
35800		A	EXPLORE NECK VESSELS	6.37	5.57	1.02	12.96	2	090
35820		A	EXPLORE CHEST VESSELS	12.26	8.35	1.51	22.12	1	090
35840		A	EXPLORE ABDOMINAL VESSELS	11.14	7.62	1.52	20.28	1	090
35860		A	EXPLORE LIMB VESSELS	4.78	6.12	1.21	12.11	2	090
35870		C	REPAIR VESSEL GRAFT DEFECT	0.00	0.00	0.00	0.00		090
35875		A	REMOVAL OF CLOT IN GRAFT	8.99	8.65	1.74	19.38	1	090
35900		A	REMOVE VESSEL GRAFT	10.37	7.57	1.54	19.48	1	090
35910		A	REVISE CIRCULATION	29.72	14.92	2.83	47.47	2	090
36000		A	PLACE NEEDLE IN VEIN	0.19	0.50	0.04	0.73	2	ZZZ
36010		A	PLACE CATHETER IN VEIN	2.56	2.22	0.32	5.10	1	ZZZ
36011		A	PLACE CATHETER IN VEIN	2.65	2.01	0.23	4.89	2	ZZZ
36012		A	PLACE CATHETER IN VEIN	3.71	2.82	0.33	6.86	2	ZZZ
36013		A	PLACE CATHETER IN ARTERY	2.65	2.01	0.23	4.89	2	ZZZ
36014		A	PLACE CATHETER IN ARTERY	3.18	2.41	0.28	5.87	2	ZZZ
36015		A	PLACE CATHETER IN ARTERY	3.71	2.82	0.33	6.86	2	ZZZ
36100		A	PLACE CATHETER IN ARTERY	3.18	2.73	0.33	6.24	2	ZZZ
36120		A	PLACE CATHETER IN ARTERY	2.12	2.45	0.31	4.88	2	ZZZ
36140		A	PLACE CATHETER IN ARTERY	2.12	1.49	0.25	3.86	2	ZZZ
36145		A	PLACE CATHETER IN VEIN SHUNT	2.12	3.46	0.52	6.10	2	ZZZ
36160		A	PLACE CATHETER IN AORTA	2.65	2.45	0.36	5.46	2	ZZZ
36200		A	PLACE CATHETER IN AORTA	3.18	2.88	0.29	6.35	2	ZZZ
36215		A	PLACE CATHETER IN ARTERIES	4.71	1.88	0.19	6.78	1	ZZZ
36216		A	PLACE CATHETER IN ARTERIES	5.57	3.48	0.28	9.33	2	ZZZ
36217		A	PLACE CATHETER IN ARTERIES	6.63	4.14	0.33	11.10	2	ZZZ
36218		A	PLACE CATHETER IN ARTERIES	1.06	0.66	0.05	1.77	2	ZZZ
36230		A	PLACE CATHETER IN ARTERY	5.01	3.28	0.27	8.56	1	ZZZ
36245		A	PLACE CATHETER IN ARTERIES	5.35	1.73	0.16	7.24	1	ZZZ

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
36246		A	PLACE CATHETER IN ARTERIES	5.57	3.48	0.28	9.33	2	ZZZ
36247		A	PLACE CATHETER IN ARTERIES	6.63	4.14	0.33	11.10	2	ZZZ
36248		A	PLACE CATHETER IN ARTERIES	1.06	0.66	0.05	1.77	2	ZZZ
36260		A	INSERTION OF INFUSION PUMP	9.76	7.11	1.49	18.36	1	090
36261		A	REVISION OF INFUSION PUMP	5.32	2.35	0.44	8.11	1	090
36262		A	REMOVAL OF INFUSION PUMP	3.90	2.04	0.42	6.36	1	090
36299		C	VESSEL INJECTION PROCEDURE	0.00	0.00	0.00	0.00		ZZZ
36400		A	DRAWING BLOOD	0.19	0.09	0.01	0.29	2	ZZZ
36405		A	DRAWING BLOOD	0.19	0.47	0.03	0.69	2	ZZZ
36406		A	DRAWING BLOOD	0.19	0.16	0.01	0.36	2	ZZZ
36410		A	DRAWING BLOOD	0.19	0.23	0.02	0.44	2	ZZZ
36415		X	DRAWING BLOOD	0.00	0.00	0.00	0.00		XXX
36420		A	DRAWING BLOOD	1.06	0.55	0.05	1.66	2	ZZZ
36425		A	DRAWING BLOOD	0.80	0.08	0.01	0.89	2	ZZZ
36430		A	BLOOD TRANSFUSION SERVICE	0.00	1.01	0.07	1.08		XXX
36440		A	BLOOD TRANSFUSION SERVICE	1.08	0.99	0.07	2.14	2	ZZZ
36450		A	EXCHANGE TRANSFUSION SERVICE	2.35	1.97	0.19	4.51	1	ZZZ
36455		A	EXCHANGE TRANSFUSION SERVICE	2.56	2.40	0.23	5.19	1	ZZZ
36460		C	TRANSFUSION SERVICE, FETAL	0.00	0.00	0.00	0.00		ZZZ
36468		N	INJECTION(S); SPIDER VEINS	0.00	0.00	0.00	0.00		XXX
36469		N	INJECTION(S); SPIDER VEINS	0.00	0.00	0.00	0.00		XXX
36470		A	INJECTION THERAPY OF VEIN	1.07	0.28	0.04	1.39	2	010
36471		A	INJECTION THERAPY OF VEINS	1.57	0.41	0.05	2.03	2	010
36481		A	INSERTION OF CATHETER, VEIN	7.37	5.59	0.65	13.61	2	000
36488		A	INSERTION OF CATHETER, VEIN	1.42	1.02	0.14	2.58	2	ZZZ
36489		A	INSERTION OF CATHETER, VEIN	1.29	1.17	0.18	2.64	2	ZZZ
36490		A	INSERTION OF CATHETER, VEIN	1.76	1.46	0.21	3.43	2	ZZZ
36491		A	INSERTION OF CATHETER, VEIN	1.51	1.80	0.33	3.64	2	ZZZ
36493		A	REPOSITIONING OF CVC	1.28	0.67	0.16	2.11	2	ZZZ
36495		D	IMPLANT INFUSION PUMP	0.00	0.00	0.00	0.00		XXX
36496		D	REVISE INFUSION PUMP	0.00	0.00	0.00	0.00		XXX
36497		D	REMOVE INFUSION PUMP	0.00	0.00	0.00	0.00		XXX
36500		A	INSERTION OF CATHETER, VEIN	3.71	0.08	0.01	3.80	2	ZZZ
36510		A	INSERTION OF CATHETER, VEIN	1.14	0.35	0.02	1.51	2	ZZZ
36520		A	PLASMA AND/OR CELL EXCHANGE	1.76	1.94	0.12	3.82	2	ZZZ
36522		A	PHOTOPHERESIS	1.76	1.61	0.10	3.47	2	ZZZ
36530		A	INSERTION OF INFUSION PUMP	5.08	5.07	1.07	11.22	2	010
36531		A	REVISION OF INFUSION PUMP	5.05	4.61	0.28	9.94	2	010
36532		A	REMOVAL OF INFUSION PUMP	3.40	1.86	0.38	5.64	2	010
36533		A	INSERTION OF ACCESS PORT	4.02	3.67	0.22	7.91	2	010
36534		A	REVISION OF ACCESS PORT	3.99	3.65	0.22	7.86	2	010
36535		A	REMOVAL OF ACCESS PORT	2.34	2.13	0.13	4.60	2	010
36600		A	WITHDRAWAL OF ARTERIAL BLOOD	0.33	0.29	0.02	0.64	1	ZZZ
36620		A	INSERTION CATHETER, ARTERY	1.21	0.70	0.14	2.05	1	ZZZ
36625		A	INSERTION CATHETER, ARTERY	2.22	0.91	0.19	3.32	1	ZZZ
36640		A	INSERTION CATHETER, ARTERY	2.21	2.45	0.42	5.08	1	ZZZ
36660		A	INSERTION CATHETER, ARTERY	1.48	1.29	0.11	2.88	2	ZZZ
36680		A	INSERT NEEDLE, BONE CAVITY	1.27	1.07	0.10	2.44	2	ZZZ
36800		A	INSERTION OF CANNULA	2.56	2.34	0.29	5.19	2	090
36810		A	INSERTION OF CANNULA	4.18	5.10	0.78	10.06	2	090
36815		A	INSERTION OF CANNULA	2.76	3.82	0.74	7.32	2	090
36820		A	INSERTION OF CANNULA	4.78	7.07	1.45	13.30	2	090
36821		A	ARTERY-VEIN FUSION	8.84	7.63	1.54	18.01	1	090
36822		A	INSERTION OF CANNULA(S)	5.31	3.59	0.47	9.37	2	090
36825		A	ARTERY-VEIN GRAFT	9.85	11.80	2.32	23.97	1	090
36830		A	ARTERY-VEIN GRAFT	8.20	12.08	2.49	22.77	1	090
36832		A	REVISE ARTERY-VEIN FISTULA	6.16	11.68	2.51	20.35	2	090
36835		C	ARTERY TO VEIN SHUNT	0.00	0.00	0.00	0.00		090
36840		C	INSERT MANDRIL	0.00	0.00	0.00	0.00		090
36845		C	FUSION WITH MANDRIL	0.00	0.00	0.00	0.00		090
36860		A	CANNULA DECLOTTING	2.12	2.71	0.45	5.28	2	000
36861		A	CANNULA DECLOTTING	2.65	5.16	1.06	8.87	2	000
37140		A	REVISION OF CIRCULATION	23.35	17.17	3.52	44.04	2	090
37145		A	REVISION OF CIRCULATION	24.41	18.05	1.81	44.27	2	090
37160		A	REVISION OF CIRCULATION	21.23	18.70	3.99	43.92	2	090
37180		A	REVISION OF CIRCULATION	24.41	14.96	2.91	42.28	2	090
37181		A	SPLICE SPLEEN/KIDNEY VEINS	26.53	17.29	3.71	47.53	2	090
37190		A	REPAIR OF CIRCULATION DEFECT	9.81	8.22	1.75	19.78	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCCPS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
37200		A	TRANSCATHETER BIOPSY	4.80	1.68	0.13	6.61	2	ZZZ
37201		A	TRANSCATHETER THERAPY INFUSE	7.64	5.79	0.68	14.11	2	ZZZ
37202		A	TRANSCATHETER THERAPY INFUSE	5.99	4.54	0.53	11.06	2	ZZZ
37203		A	TRANSCATHETER RETRIEVAL	5.31	4.02	0.47	9.80	2	ZZZ
37204		A	TRANSCATHETER OCCLUSION	19.11	14.49	1.69	35.29	2	ZZZ
37565		A	LIGATION OF NECK VEIN	4.10	3.99	0.78	8.87	2	090
37600		A	LIGATION OF NECK ARTERY	4.10	6.65	0.84	11.59	2	090
37605		A	LIGATION OF NECK ARTERY	4.88	5.85	1.09	11.82	2	090
37606		A	LIGATION OF NECK ARTERY	4.88	7.05	0.76	12.69	2	090
37609		A	TEMPORAL ARTERY PROCEDURE	2.40	2.33	0.40	5.13	1	010
37615		A	LIGATION OF NECK ARTERY	4.63	7.27	1.16	13.06	2	090
37616		A	LIGATION OF CHEST ARTERY	15.48	4.44	0.87	20.79	1	090
37617		A	LIGATION OF ABDOMEN ARTERY	14.96	8.43	1.63	25.02	1	090
37618		A	LIGATION OF EXTREMITY ARTERY	4.10	5.56	1.11	10.77	2	090
37620		A	REVISION OF MAJOR VEIN	9.73	9.29	1.56	20.58	2	090
37650		A	REVISION OF MAJOR VEIN	4.63	4.23	0.56	9.42	2	090
37660		A	REVISION OF MAJOR VEIN	10.17	6.06	1.12	17.35	1	090
37700		A	REVISE LEG VEIN	3.71	3.84	0.77	8.32	2	090
37720		A	REMOVAL OF LEG VEIN	4.78	5.39	1.09	11.26	2	090
37730		A	REMOVAL OF LEG VEINS	5.84	7.32	1.48	14.64	2	090
37735		A	REMOVAL OF LEG VEINS/LESION	10.43	8.78	1.77	20.98	1	090
37760		A	REVISION OF LEG VEINS	10.43	7.88	1.60	19.91	2	090
37780		A	REVISION OF LEG VEIN	3.71	2.00	0.36	6.07	2	090
37785		A	REVISE SECONDARY VARICOSITY	3.75	1.03	0.19	4.97	1	090
37783		C	REVASCLARIZATION, PENIS	0.00	0.00	0.00	0.00		090
37799		C	VASCULAR SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
38100		A	REMOVAL OF SPLEEN, TOTAL	12.63	9.01	1.90	23.54	1	090
38101		A	REMOVAL OF SPLEEN, PARTIAL	13.27	7.36	1.59	22.22	2	090
38115		A	REPAIR OF RUPTURED SPLEEN	13.27	8.05	1.57	22.89	2	090
38200		A	INJECTION FOR SPLEEN X-RAY	2.79	1.80	0.15	4.74	2	ZZZ
38230		A	BONE MARROW COLLECTION	3.33	2.93	0.22	6.48	1	ZZZ
38240		A	BONE MARROW TRANSPLANTATION	2.36	2.19	0.14	4.69	1	ZZZ
38241		A	BONE MARROW TRANSPLANTATION	2.36	2.15	0.13	4.64	2	ZZZ
38300		A	DRAINAGE LYMPH NODE LESION	1.56	0.62	0.10	2.28	1	010
38305		A	DRAINAGE LYMPH NODE LESION	4.47	2.07	0.37	6.91	1	090
38308		A	INCISION OF LYMPH CHANNELS	4.79	3.55	0.47	8.81	1	090
38380		A	THORACIC DUCT PROCEDURE	6.88	4.68	0.80	12.36	1	090
38381		A	THORACIC DUCT PROCEDURE	12.74	7.96	1.58	22.28	2	090
38382		A	THORACIC DUCT PROCEDURE	9.73	5.09	1.18	16.00	2	090
38500		A	BIOPSY/REMOVAL, LYMPH NODE(S)	2.98	1.68	0.32	4.98	1	010
38505		A	NEEDLE BIOPSY, LYMPH NODE(S)	1.20	1.17	0.17	2.54	2	000
38510		A	BIOPSY/REMOVAL, LYMPH NODE(S)	4.10	2.67	0.47	7.24	1	090
38520		A	BIOPSY/REMOVAL, LYMPH NODE(S)	5.11	3.15	0.60	8.86	1	090
38525		A	BIOPSY/REMOVAL, LYMPH NODE(S)	4.61	2.73	0.57	7.91	1	090
38530		A	BIOPSY/REMOVAL, LYMPH NODE(S)	6.13	3.34	0.69	10.16	1	090
38542		A	EXPLORE DEEP NODE(S), NECK	5.70	4.50	0.63	10.83	1	090
38550		A	REMOVAL NECK/ARMPIT LESION	6.23	3.40	0.67	10.30	1	090
38555		A	REMOVAL NECK/ARMPIT LESION	10.44	7.66	1.46	19.56	1	090
38562		A	REMOVAL, PELVIC LYMPH NODES	10.17	7.25	1.27	18.69	1	090
38564		A	REMOVAL, ABDOMEN LYMPH NODES	10.53	7.79	1.59	19.91	1	090
38700		A	REMOVAL OF LYMPH NODES, NECK	7.96	10.16	1.38	19.50	2	090
38720		A	REMOVAL OF LYMPH NODES, NECK	12.95	16.76	2.15	31.86	1	090
38724		A	REMOVAL OF LYMPH NODES, NECK	13.94	15.13	2.11	31.18	1	090
38740		A	REMOVE ARMPIT LYMPH NODES	6.61	4.97	1.05	12.63	1	090
38745		A	REMOVE ARMPITS LYMPH NODES	8.52	8.72	1.85	19.09	1	090
38760		A	REMOVE GROIN LYMPH NODES	7.77	6.98	1.43	16.18	1	090
38765		A	REMOVE GROIN LYMPH NODES	13.35	13.35	2.55	29.25	1	090
38770		A	REMOVE PELVIS LYMPH NODES	12.74	16.23	1.82	30.79	2	090
38780		A	REMOVE ABDOMEN LYMPH NODES	15.98	16.92	3.29	36.19	1	090
38790		A	INJECTION FOR LYMPHATIC XRAY	1.36	2.48	0.20	4.04	2	ZZZ
38794		A	ACCESS THORACIC LYMPH DUCT	4.27	2.99	0.39	7.65	1	090
38999		C	BLOOD/LYMPH SYSTEM PROCEDURE	0.00	0.00	0.00	0.00		YYY
39000		A	EXPLORATION OF CHEST	5.31	6.38	1.13	12.82	2	090
39010		A	EXPLORATION OF CHEST	13.07	10.08	1.86	25.01	1	090
39020		A	EXPLORATION OF CHEST	8.80	13.91	2.48	25.19	1	090
39200		A	REMOVAL CHEST LESION	10.73	12.20	2.25	25.18	1	090
39220		A	REMOVAL CHEST LESION	12.75	15.75	2.98	31.48	1	090
39400		A	VISUALIZATION OF CHEST	5.39	5.40	1.00	11.79	2	010

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
39499		C	CHEST PROCEDURE	0.00	0.00	0.00	0.00		YYY
39501		A	REPAIR DIAPHRAGM LACERATION	12.74	11.23	2.21	26.18	2	090
39502		A	REPAIR PARAESOPHAGEAL HERNIA	13.80	12.57	2.58	28.95	2	090
39503		C	REPAIR OF DIAPHRAGM HERNIA	0.00	0.00	0.00	0.00		090
39520		A	REPAIR OF DIAPHRAGM HERNIA	12.74	13.21	2.59	28.54	2	090
39530		A	REPAIR OF DIAPHRAGM HERNIA	14.99	14.82	2.86	32.67	1	090
39531		A	REPAIR OF DIAPHRAGM HERNIA	16.05	10.53	1.89	28.47	2	090
39540		A	REPAIR OF DIAPHRAGM HERNIA	12.74	12.62	2.64	28.00	2	090
39541		A	REPAIR OF DIAPHRAGM HERNIA	13.80	12.82	2.50	29.12	2	090
39545		A	REVISION OF DIAPHRAGM	12.74	8.51	1.62	22.87	2	090
39547		A	REVISION OF DIAPHRAGM	12.74	8.05	0.97	21.76	2	090
39599		C	DIAPHRAGM SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
40490		A	BIOPSY OF LIP	1.29	0.78	0.07	2.14	2	000
40500		A	PARTIAL EXCISION OF LIP	4.30	7.32	0.99	12.61	2	090
40510		A	PARTIAL EXCISION OF LIP	4.81	6.24	0.87	11.92	1	090
40520		A	PARTIAL EXCISION OF LIP	4.78	4.74	0.72	10.24	1	090
40525		A	RECONSTRUCT LIP WITH FLAP	7.65	9.96	1.51	19.12	1	090
40527		A	RECONSTRUCT LIP WITH FLAP	9.19	11.93	1.74	22.86	1	090
40530		A	PARTIAL REMOVAL OF LIP	5.42	5.38	0.78	11.58	1	090
40650		A	REPAIR LIP	3.68	4.90	0.69	9.27	1	090
40652		A	REPAIR LIP	4.30	5.60	0.83	10.73	1	090
40654		A	REPAIR LIP	5.41	7.32	1.05	13.78	1	090
40700		A	REPAIR CLEFT LIP/NASAL	12.68	8.91	1.35	22.94	1	090
40701		A	REPAIR CLEFT LIP/NASAL	15.91	21.32	1.71	38.94	1	090
40702		A	REPAIR CLEFT LIP/NASAL	7.96	9.47	0.71	18.14	2	090
40720		A	REPAIR CLEFT LIP/NASAL	13.60	10.11	1.88	25.59	1	090
40761		A	REPAIR CLEFT LIP/NASAL	14.76	11.42	1.83	28.01	1	090
40799		C	LIP SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
40800		A	DRAINAGE OF MOUTH LESION	1.17	0.78	0.07	2.02	2	010
40801		A	DRAINAGE OF MOUTH LESION	2.61	1.79	0.16	4.56	2	010
40804		A	REMOVAL FOREIGN BODY, MOUTH	1.26	0.62	0.06	1.94	2	010
40805		A	REMOVAL FOREIGN BODY, MOUTH	2.79	2.63	0.31	5.73	2	010
40806		A	INCISION OF LIP FOLD	0.32	0.37	0.03	0.72	2	010
40808		A	BIOPSY OF MOUTH LESION	0.96	0.80	0.08	1.84	2	010
40810		A	EXCISION OF MOUTH LESION	1.33	1.24	0.11	2.68	2	010
40812		A	EXCISE/REPAIR MOUTH LESION	2.39	1.58	0.14	4.11	2	010
40814		A	EXCISE/REPAIR MOUTH LESION	3.45	3.40	0.33	7.18	2	090
40816		A	EXCISION OF MOUTH LESION	3.71	3.39	0.34	7.44	2	090
40818		A	EXCISE ORAL MUCOSA FOR GRAFT	2.39	2.38	0.21	4.98	2	090
40819		A	EXCISE LIP OR CHEEK FOLD	2.39	1.30	0.14	3.83	2	090
40820		A	TREATMENT OF MOUTH LESION	1.33	0.57	0.06	1.96	2	010
40830		A	REPAIR MOUTH LACERATION	1.80	0.71	0.07	2.58	2	010
40831		A	REPAIR MOUTH LACERATION	2.54	2.05	0.22	4.81	2	010
40840		N	RECONSTRUCTION OF MOUTH	0.00	0.00	0.00	0.00		XXX
40842		N	RECONSTRUCTION OF MOUTH	0.00	0.00	0.00	0.00		XXX
40843		N	RECONSTRUCTION OF MOUTH	0.00	0.00	0.00	0.00		XXX
40844		N	RECONSTRUCTION OF MOUTH	0.00	0.00	0.00	0.00		XXX
40845		N	RECONSTRUCTION OF MOUTH	0.00	0.00	0.00	0.00		XXX
40899		C	MOUTH SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
41000		A	DRAINAGE OF MOUTH LESION	1.32	0.80	0.08	2.20	2	010
41005		A	DRAINAGE OF MOUTH LESION	1.28	0.66	0.07	2.01	2	010
41006		A	DRAINAGE OF MOUTH LESION	3.19	3.27	0.32	6.78	1	090
41007		A	DRAINAGE OF MOUTH LESION	3.04	3.06	0.31	6.41	1	090
41008		A	DRAINAGE OF MOUTH LESION	3.33	1.11	0.11	4.55	1	090
41009		A	DRAINAGE OF MOUTH LESION	3.53	3.49	0.35	7.37	1	090
41010		A	INCISION OF TONGUE FOLD	1.25	1.01	0.09	2.35	1	010
41015		A	DRAINAGE OF MOUTH LESION	3.92	0.92	0.10	4.94	1	090
41016		A	DRAINAGE OF MOUTH LESION	3.92	3.89	0.39	8.20	2	090
41017		A	DRAINAGE OF MOUTH LESION	3.92	1.48	0.14	5.54	2	090
41018		A	DRAINAGE OF MOUTH LESION	3.92	4.14	0.40	8.46	2	090
41100		A	BIOPSY OF TONGUE	1.67	0.84	0.08	2.59	1	010
41105		A	BIOPSY OF TONGUE	1.45	1.08	0.12	2.65	1	010
41108		A	BIOPSY OF FLOOR OF MOUTH	1.05	0.90	0.09	2.04	1	010
41110		A	EXCISION OF TONGUE LESION	1.54	1.37	0.15	3.06	1	010
41112		A	EXCISION OF TONGUE LESION	2.78	2.52	0.24	5.54	1	090
41113		A	EXCISION OF TONGUE LESION	3.25	3.60	0.38	7.23	1	090
41114		A	EXCISION OF TONGUE LESION	8.30	6.74	0.77	15.81	1	090
41115		A	EXCISION OF TONGUE FOLD	1.78	1.87	0.17	3.82	1	010

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
41116		A	EXCISION OF MOUTH LESION	2.49	2.62	0.28	5.39	1	090
41120		A	PARTIAL REMOVAL OF TONGUE	9.31	7.67	0.93	17.91	1	090
41130		A	PARTIAL REMOVAL OF TONGUE	10.82	9.55	1.20	21.57	1	090
41135		A	TONGUE AND NECK SURGERY	15.06	22.35	2.79	40.20	2	090
41140		A	REMOVAL OF TONGUE	24.72	19.90	2.58	47.20	1	090
41145		A	TONGUE REMOVAL; NECK SURGERY	29.07	24.01	3.11	56.19	2	090
41150		A	TONGUE, MOUTH, JAW SURGERY	20.41	19.98	2.59	42.98	1	090
41153		A	TONGUE, MOUTH, NECK SURGERY	22.32	26.34	3.19	51.85	1	090
41155		A	TONGUE, JAW, & NECK SURGERY	24.66	31.77	3.95	60.38	2	090
41250		A	REPAIR TONGUE LACERATION	1.95	1.12	0.11	3.18	1	010
41251		A	REPAIR TONGUE LACERATION	2.34	2.18	0.22	4.74	1	010
41252		A	REPAIR TONGUE LACERATION	3.08	2.48	0.27	5.83	2	010
41500		A	FIXATION OF TONGUE	3.69	3.47	0.27	7.43	1	090
41510		A	TONGUE TO LIP SURGERY	3.50	2.66	0.47	6.63	1	090
41520		A	RECONSTRUCTION, TONGUE FOLD	2.77	3.03	0.29	6.09	1	090
41599		C	TONGUE AND MOUTH SURGERY	0.00	0.00	0.00	0.00		YYY
41800		A	DRAINAGE OF GUM LESION	1.17	0.73	0.07	1.97	2	010
41805		A	REMOVAL FOREIGN BODY, GUM	1.26	0.88	0.08	2.22	2	010
41806		A	REMOVAL FOREIGN BODY, JAWBONE	2.79	1.73	0.15	4.67	2	010
41820		N	EXCISION, GUM, EACH QUADRANT	0.00	0.00	0.00	0.00		XXX
41821		N	EXCISION OF GUM FLAP	0.00	0.00	0.00	0.00		XXX
41822		N	EXCISION OF GUM LESION	0.00	0.00	0.00	0.00		XXX
41823		N	EXCISION OF GUM LESION	0.00	0.00	0.00	0.00		XXX
41825		A	EXCISION OF GUM LESION	1.33	1.57	0.14	3.04	2	010
41826		A	EXCISION OF GUM LESION	2.39	2.18	0.19	4.76	2	010
41827		A	EXCISION OF GUM LESION	3.45	3.98	0.39	7.82	2	090
41828		N	EXCISION OF GUM LESION	0.00	0.00	0.00	0.00		XXX
41830		N	REMOVAL OF GUM TISSUE	0.00	0.00	0.00	0.00		XXX
41850		N	TREATMENT OF GUM LESION	0.00	0.00	0.00	0.00		XXX
41870		N	GUM GRAFT	0.00	0.00	0.00	0.00		XXX
41872		N	REPAIR GUM	0.00	0.00	0.00	0.00		XXX
41874		N	REPAIR TOOTH SOCKET	0.00	0.00	0.00	0.00		XXX
41899		C	DENTAL SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
42000		A	DRAINAGE MOUTH ROOF LESION	1.24	0.66	0.06	1.96	2	010
42100		A	BIOPSY ROOF OF MOUTH	1.33	0.83	0.08	2.24	1	010
42104		A	EXCISION LESION, MOUTH ROOF	1.68	1.71	0.17	3.56	1	010
42106		A	EXCISION LESION, MOUTH ROOF	2.78	2.33	0.22	5.33	1	010
42107		A	EXCISION LESION, MOUTH ROOF	4.43	5.17	0.53	10.13	1	090
42120		A	REMOVE PALATE/LESION	5.68	8.93	1.06	15.67	1	090
42140		A	EXCISION OF UVULA	1.63	1.42	0.15	3.20	1	090
42145		A	REPAIR, PALATE, PHARYNX/UVULA	7.42	14.36	1.53	23.31	1	090
42160		A	TREATMENT MOUTH ROOF LESION	1.84	1.61	0.16	3.61	1	010
42180		A	REPAIR PALATE	2.58	2.36	0.27	5.21	1	010
42182		A	REPAIR PALATE	3.98	3.66	0.40	8.04	1	010
42200		A	RECONSTRUCT CLEFT PALATE	9.07	7.90	1.02	17.99	1	090
42205		A	RECONSTRUCT CLEFT PALATE	9.44	11.40	0.83	21.67	1	090
42210		A	RECONSTRUCT CLEFT PALATE	10.55	13.19	1.00	24.74	1	090
42215		A	RECONSTRUCT CLEFT PALATE	8.87	8.10	0.91	17.88	1	090
42220		A	RECONSTRUCT CLEFT PALATE	7.01	5.69	0.85	13.55	1	090
42225		A	RECONSTRUCT CLEFT PALATE	9.57	7.27	1.13	17.97	1	090
42226		A	LENGTHENING OF PALATE	9.93	8.32	0.91	19.16	1	090
42227		A	LENGTHENING OF PALATE	9.37	7.81	0.40	17.58	1	090
42235		A	REPAIR PALATE	7.90	5.84	0.52	14.26	1	090
42260		A	REPAIR NOSE TO LIP FISTULA	4.40	4.19	0.46	9.05	1	090
42280		A	PREPARATION, PALATE MOLD	1.57	2.10	0.17	3.84	1	010
42281		A	INSERTION, PALATE PROSTHESIS	1.86	1.55	0.15	3.56	1	010
42299		C	PALATE/UVULA SURGERY	0.00	0.00	0.00	0.00		YYY
42300		A	DRAINAGE OF SALIVARY GLAND	1.98	1.01	0.12	3.11	2	010
42305		A	DRAINAGE OF SALIVARY GLAND	5.88	2.29	0.28	8.45	1	090
42310		A	DRAINAGE OF SALIVARY GLAND	1.59	1.08	0.12	2.79	2	010
42320		A	DRAINAGE OF SALIVARY GLAND	2.43	1.92	0.23	4.58	2	010
42325		A	CREATE SALIVARY CYST DRAIN	2.80	2.23	0.21	5.24	1	090
42326		A	CREATE SALIVARY CYST DRAIN	3.85	4.58	0.34	8.77	1	090
42330		A	REMOVAL OF SALIVARY STONE	2.27	1.15	0.12	3.54	1	010
42335		A	REMOVAL OF SALIVARY STONE	3.38	2.60	0.28	6.26	1	090
42340		A	REMOVAL OF SALIVARY STONE	4.71	4.48	0.48	9.67	1	090
42400		A	BIOPSY OF SALIVARY GLAND	0.82	0.83	0.10	1.75	2	000
42405		A	BIOPSY OF SALIVARY GLAND	3.42	1.63	0.20	5.25	1	010

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
42408		A	EXCISION OF SALIVARY CYST	4.65	3.42	0.40	8.47	1	090
42409		A	DRAINAGE OF SALIVARY CYST	2.86	2.96	0.31	6.13	1	090
42410		A	EXCISE PAROTID GLAND/LESION	9.36	6.26	0.97	16.59	1	090
42415		A	EXCISE PAROTID GLAND/LESION	16.98	13.36	1.77	32.11	2	090
42420		A	EXCISE PAROTID GLAND/LESION	19.64	15.61	1.96	37.21	2	090
42425		A	EXCISE PAROTID GLAND/LESION	13.02	11.70	1.51	26.23	1	090
42426		A	EXCISE PAROTID GLAND/LESION	17.27	25.42	3.38	46.07	2	090
42440		A	EXCISION SUBMAXILLARY GLAND	6.96	8.41	1.04	16.41	1	090
42450		A	EXCISION SUBLINGUAL GLAND	4.62	3.61	0.36	8.59	1	090
42500		A	REPAIR SALIVARY DUCT	4.28	4.85	0.53	9.66	1	090
42505		A	REPAIR SALIVARY DUCT	6.24	7.74	0.91	14.89	1	090
42507		A	PAROTID DUCT DIVERSION	6.28	4.90	0.71	11.89	1	090
42508		A	PAROTID DUCT DIVERSION	9.11	8.01	0.99	18.11	1	090
42509		A	PAROTID DUCT DIVERSION	11.68	7.70	1.30	20.68	1	090
42510		A	PAROTID DUCT DIVERSION	8.13	8.06	0.88	17.07	1	090
42550		A	INJECTION FOR SALIVARY X-RAY	1.32	0.46	0.04	1.82	2	ZZZ
42600		A	CLOSURE OF SALIVARY FISTULA	4.82	4.09	0.49	9.40	1	090
42650		A	DILATION OF SALIVARY DUCT	1.07	0.41	0.04	1.52	2	010
42660		A	DILATION OF SALIVARY DUCT	1.19	0.53	0.06	1.78	2	000
42665		A	LIGATION OF SALIVARY DUCT	2.56	2.15	0.26	4.97	1	090
42699		C	SALIVARY SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
42700		A	DRAINAGE OF TONSIL ABSCESS	1.66	0.89	0.10	2.65	1	010
42720		A	DRAINAGE OF THROAT ABSCESS	2.75	2.00	0.23	4.98	1	010
42725		A	DRAINAGE OF THROAT ABSCESS	5.32	4.69	0.57	10.58	1	090
42800		A	BIOPSY OF THROAT	1.41	0.78	0.08	2.27	1	010
42802		A	BIOPSY OF THROAT	1.57	1.07	0.12	2.76	1	010
42804		A	BIOPSY OF UPPER NOSE/THROAT	1.26	1.14	0.13	2.53	1	010
42806		A	BIOPSY OF UPPER NOSE/THROAT	1.61	1.48	0.16	3.25	1	010
42808		A	EXCISE PHARYNX LESION	2.37	2.65	0.30	5.32	1	010
42809		A	REMOVE PHARYNX FOREIGN BODY	1.85	0.86	0.08	2.79	1	010
42810		A	EXCISION OF NECK CYST	4.18	3.30	0.50	7.98	1	090
42815		A	EXCISION OF NECK CYST	7.12	8.92	1.17	17.21	1	090
42820		A	REMOVE TONSILS AND ADENOIDS	3.79	3.31	0.33	7.43	1	090
42821		A	REMOVE TONSILS AND ADENOIDS	4.32	4.14	0.49	8.95	1	090
42825		A	REMOVAL OF TONSILS	3.38	2.79	0.34	6.51	1	090
42826		A	REMOVAL OF TONSILS	3.36	4.06	0.45	7.87	1	090
42830		A	REMOVAL OF ADENOIDS	2.62	1.95	0.28	4.85	1	090
42831		A	REMOVAL OF ADENOIDS	2.75	2.49	0.26	5.50	1	090
42835		A	REMOVAL OF ADENOIDS	2.34	1.95	0.10	4.39	1	090
42836		A	REMOVAL OF ADENOIDS	3.26	2.94	0.32	6.52	1	090
42842		A	EXTENSIVE SURGERY OF THROAT	8.57	7.05	0.77	16.39	1	090
42844		A	EXTENSIVE SURGERY OF THROAT	13.41	11.46	1.36	26.23	1	090
42845		A	EXTENSIVE SURGERY OF THROAT	23.05	19.63	2.33	45.01	1	090
42860		A	EXCISION OF TONSIL TAGS	2.25	2.00	0.22	4.47	1	090
42870		A	EXCISION OF LINGUAL TONSIL	5.44	2.45	0.27	8.16	1	090
42880		A	EXCISE NOSE/THROAT LESION	6.34	4.87	0.56	11.77	1	090
42890		A	PARTIAL REMOVAL OF PHARYNX	12.30	9.47	1.08	22.85	1	090
42892		A	REVISION OF PHARYNGEAL WALLS	14.70	11.51	1.34	27.55	1	090
42894		A	REVISION OF PHARYNGEAL WALLS	21.80	16.92	1.92	40.64	1	090
42900		A	REPAIR THROAT WOUND	5.26	4.49	0.51	10.26	1	010
42950		A	RECONSTRUCTION OF THROAT	8.12	10.39	1.15	19.66	1	090
42953		A	REPAIR THROAT, ESOPHAGUS	8.65	6.68	0.98	16.31	1	090
42955		A	SURGICAL OPENING OF THROAT	6.85	3.50	0.45	10.80	1	090
42960		A	CONTROL THROAT BLEEDING	2.41	1.13	0.12	3.66	1	010
42961		A	CONTROL THROAT BLEEDING	5.46	1.84	0.20	7.50	1	090
42962		A	CONTROL THROAT BLEEDING	6.99	6.31	0.72	14.02	1	090
42970		A	CONTROL NOSE/THROAT BLEEDING	5.03	1.08	0.10	6.21	1	090
42971		A	CONTROL NOSE/THROAT BLEEDING	5.85	3.06	0.35	9.26	1	090
42972		A	CONTROL NOSE/THROAT BLEEDING	6.90	4.79	0.77	12.46	1	090
42999		C	THROAT SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
43000		A	INCISION OF ESOPHAGUS	6.99	6.11	0.85	13.95	1	090
43020		A	INCISION OF ESOPHAGUS	8.14	6.93	0.75	15.82	1	090
43030		A	THROAT MUSCLE SURGERY	7.54	10.36	1.28	19.18	1	090
43040		A	INCISION OF ESOPHAGUS	10.61	7.24	1.25	19.10	2	090
43045		A	INCISION OF ESOPHAGUS	19.84	13.13	2.49	35.46	1	090
43100		A	EXCISION OF ESOPHAGUS LESION	8.92	6.52	1.00	16.44	1	090
43101		A	EXCISION OF ESOPHAGUS LESION	15.92	10.00	1.97	27.89	2	090
43105		A	REMOVAL OF UPPER ESOPHAGUS	19.11	16.04	1.98	37.13	2	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
43106		A	REMOVAL OF UPPER ESOPHAGUS	22.29	19.84	2.29	44.42	2	090
43110		A	PARTIAL REMOVAL OF ESOPHAGUS	27.65	22.82	4.45	54.92	1	090
43111		A	PARTIAL REMOVAL OF ESOPHAGUS	27.64	16.07	3.52	47.23	2	090
43115		A	PARTIAL REMOVAL OF ESOPHAGUS	31.84	26.63	5.02	63.49	2	090
43119		A	REMOVAL OF ESOPHAGUS	28.66	23.71	4.66	57.03	2	090
43120		A	REMOVE ESOPHAGUS & STOMACH	27.46	22.51	4.42	54.39	1	090
43130		A	REMOVAL OF ESOPHAGUS POUCH	11.25	11.08	1.69	24.02	1	090
43135		A	REMOVAL OF ESOPHAGUS POUCH	15.92	12.35	2.28	30.55	2	090
43136		A	FIXATION OF ESOPHAGUS POUCH	10.77	8.11	1.20	20.08	1	090
43200		A	ESOPHAGUS ENDOSCOPY	1.68	2.81	0.27	4.76	2	000
43202		A	ESOPHAGUS ENDOSCOPY, BIOPSY	2.00	3.42	0.32	5.74	2	000
43204		A	ESOPHAGUS ENDOSCOPY & INJECT	2.74	5.55	0.37	8.66	2	000
43215		A	ESOPHAGUS ENDOSCOPY	2.74	4.58	0.49	7.81	2	000
43217		A	ESOPHAGUS ENDOSCOPY	2.95	4.73	0.38	8.06	2	000
43219		A	ESOPHAGUS ENDOSCOPY	2.95	4.22	0.35	7.52	2	000
43220		A	ESOPHAGUS ENDOSCOPY, DILATION	2.21	3.46	0.31	5.98	2	000
43226		A	ESOPHAGUS ENDOSCOPY, DILATION	2.00	4.01	0.27	6.28	2	000
43227		A	ESOPHAGUS ENDOSCOPY, REPAIR	3.80	5.17	0.35	9.32	2	000
43228		A	ESOPHAGUS ENDOSCOPY, REPAIR	3.80	5.04	0.40	9.24	2	000
43234		A	UPPER GI ENDOSCOPY, EXAM	2.12	3.20	0.31	5.63	2	000
43235		A	UPPER GI ENDOSCOPY, DIAGNOSIS	2.52	3.86	0.30	6.68	1	000
43239		A	UPPER GI ENDOSCOPY, BIOPSY	2.83	4.45	0.34	7.62	2	000
43241		A	UPPER GI ENDOSCOPY WITH TUBE	2.73	4.89	0.39	8.01	2	000
43243		A	UPPER GI ENDOSCOPY & INJECT.	3.58	5.92	0.41	9.91	2	000
43245		A	OPERATIVE UPPER GI ENDOSCOPY	3.58	4.99	0.42	8.99	2	000
43246		A	PLACE GASTROSTOMY TUBE	4.57	6.31	0.55	11.43	1	000
43247		A	OPERATIVE UPPER GI ENDOSCOPY	3.58	5.06	0.40	9.04	2	000
43251		A	OPERATIVE UPPER GI ENDOSCOPY	3.79	5.68	0.45	9.92	2	000
43255		A	OPERATIVE UPPER GI ENDOSCOPY	4.64	5.93	0.40	10.97	2	000
43258		A	OPERATIVE UPPER GI ENDOSCOPY	4.64	5.70	0.40	10.74	2	000
43260		A	ENDOSCOPY, BILE DUCT/PANCREAS	6.29	6.31	0.41	13.01	2	000
43262		A	ENDOSCOPY, BILE DUCT/PANCREAS	7.79	9.48	0.62	17.89	2	000
43263		A	ENDOSCOPY, BILE DUCT/PANCREAS	6.52	6.14	0.40	13.06	2	000
43264		A	ENDOSCOPY, BILE DUCT/PANCREAS	9.38	9.40	0.65	19.43	2	000
43265		A	ENDOSCOPY, BILE DUCT/PANCREAS	9.38	7.19	0.52	17.09	2	000
43267		A	ENDOSCOPY, BILE DUCT/PANCREAS	7.79	7.81	0.51	16.11	2	000
43268		A	ENDOSCOPY, BILE DUCT/PANCREAS	7.79	9.20	0.60	17.59	2	000
43269		A	ENDOSCOPY, BILE DUCT/PANCREAS	6.37	7.75	0.55	14.67	2	000
43271		A	ENDOSCOPY, BILE DUCT/PANCREAS	7.79	8.03	0.53	16.35	2	000
43272		A	ENDOSCOPY, BILE DUCT/PANCREAS	7.79	5.89	0.44	14.12	2	000
43300		A	REPAIR OF ESOPHAGUS	9.20	7.27	1.04	17.51	1	090
43305		A	REPAIR ESOPHAGUS AND FISTULA	14.20	14.44	1.87	30.51	1	090
43310		A	REPAIR OF ESOPHAGUS	14.79	17.91	3.40	36.10	1	090
43312		A	REPAIR ESOPHAGUS AND FISTULA	19.56	14.45	2.43	36.44	2	090
43320		A	FUSE ESOPHAGUS & STOMACH	15.01	11.76	1.93	28.70	1	090
43321		A	FUSE ESOPHAGUS & STOMACH	15.57	13.71	2.70	31.98	1	090
43324		A	REVISE ESOPHAGUS & STOMACH	14.81	12.52	2.66	29.99	2	090
43325		A	REVISE ESOPHAGUS & STOMACH	15.41	12.23	2.42	30.06	1	090
43326		A	REVISE ESOPHAGUS & STOMACH	15.14	7.92	1.84	24.90	1	090
43330		A	REPAIR OF ESOPHAGUS	15.04	11.97	2.52	29.53	1	090
43331		A	REPAIR OF ESOPHAGUS	15.52	15.10	2.79	33.41	1	090
43340		A	FUSE ESOPHAGUS & INTESTINE	14.93	13.12	2.65	30.70	1	090
43341		A	FUSE ESOPHAGUS & INTESTINE	16.08	10.43	1.65	28.16	1	090
43350		A	SURGICAL OPENING, ESOPHAGUS	11.86	8.31	1.21	21.38	1	090
43351		A	SURGICAL OPENING, ESOPHAGUS	14.14	9.25	1.61	25.00	1	090
43352		A	SURGICAL OPENING, ESOPHAGUS	11.51	9.34	1.55	22.40	1	090
43400		A	LIGATE ESOPHAGUS VEINS	16.39	11.40	1.72	29.51	1	090
43401		A	ESOPHAGUS SURGERY FOR VEINS	17.14	10.11	2.04	29.29	1	090
43410		A	REPAIR ESOPHAGUS WOUND	10.13	6.76	1.22	18.11	1	090
43415		A	REPAIR ESOPHAGUS WOUND	16.72	13.42	2.65	32.79	1	090
43420		A	REPAIR ESOPHAGUS OPENING	10.74	6.20	0.82	17.76	1	090
43425		A	REPAIR ESOPHAGUS OPENING	16.42	10.47	1.80	28.69	1	090
43450		A	DILATE ESOPHAGUS	1.46	0.77	0.06	2.29	2	000
43451		A	REDILATE ESOPHAGUS	1.32	0.65	0.05	2.02	2	000
43453		A	DILATE ESOPHAGUS	1.59	1.59	0.11	3.29	2	000
43455		A	DILATE ESOPHAGUS	3.18	2.27	0.15	5.60	2	000
43456		A	DILATE ESOPHAGUS	3.71	2.60	0.25	6.56	2	000
43460		A	PRESSURE TREATMENT ESOPHAGUS	5.35	1.76	0.15	7.26	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
43499		C	ESOPHAGUS SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
43500		A	SURGICAL OPENING OF STOMACH	8.00	6.46	1.27	15.73	1	090
43501		A	SURGICAL REPAIR OF STOMACH	11.72	9.04	1.92	22.68	1	090
43510		A	SURGICAL OPENING OF STOMACH	9.76	8.73	0.99	19.48	1	090
43520		A	INCISION OF PYLORIC MUSCLE	7.38	4.72	0.92	13.02	1	090
43600		A	BIOPSY OF STOMACH	2.02	0.53	0.05	2.60	2	000
43605		A	BIOPSY OF STOMACH	8.67	6.23	1.36	16.26	1	090
43610		A	EXCISION OF STOMACH LESION	10.65	8.61	1.80	21.06	1	090
43620		A	REMOVAL OF STOMACH	22.16	16.20	3.36	41.72	1	090
43625		A	REMOVAL OF STOMACH	23.61	21.94	4.81	50.36	1	090
43630		A	PARTIAL REMOVAL OF STOMACH	19.11	13.09	2.81	35.01	2	090
43635		A	PARTIAL REMOVAL OF STOMACH	20.17	13.58	2.91	36.66	2	090
43638		A	PARTIAL REMOVAL OF STOMACH	21.23	13.43	2.88	37.54	2	090
43640		A	VAGOTOMY & PYLORUS REPAIR	11.00	10.90	2.30	24.20	2	090
43641		A	VAGOTOMY & PYLORUS REPAIR	10.38	10.89	2.29	23.56	2	090
43750		A	PLACE GASTROSTOMY TUBE	6.18	4.59	0.60	11.37	1	090
43760		A	CHANGE GASTROSTOMY TUBE	1.15	0.73	0.09	1.97	2	000
43761		A	REPOSITION GASTROSTOMY TUBE	2.12	1.11	0.26	3.49	2	000
43800		A	RECONSTRUCTION OF PYLORUS	9.92	7.22	1.55	18.69	1	090
43810		A	FUSION OF STOMACH AND BOWEL	10.62	8.04	1.61	20.27	1	090
43820		A	FUSION OF STOMACH AND BOWEL	11.00	8.73	1.84	21.57	1	090
43825		A	FUSION OF STOMACH AND BOWEL	11.91	11.68	2.43	26.02	2	090
43830		A	PLACE GASTROSTOMY TUBE	5.09	6.90	1.25	13.24	2	090
43831		A	PLACE GASTROSTOMY TUBE	6.76	5.48	0.98	13.22	1	090
43832		A	PLACE GASTROSTOMY TUBE	11.25	8.38	1.44	21.07	1	090
43840		A	REPAIR OF STOMACH LESION	11.02	8.26	1.75	21.03	1	090
43844		A	GASTRIC BYPASS FOR OBESITY	18.67	9.76	2.27	30.70	1	090
43845		A	GASTRIC REVISION FOR OBESITY	16.85	14.45	3.09	34.39	1	090
43846		A	GASTRIC BYPASS FOR OBESITY	18.73	15.59	3.48	37.80	1	090
43850		A	REVISE STOMACH-BOWEL FUSION	19.11	12.27	2.37	33.75	2	090
43855		A	REVISE STOMACH-BOWEL FUSION	20.17	11.01	2.41	33.59	2	090
43860		A	REVISE STOMACH-BOWEL FUSION	19.11	12.08	2.64	33.83	2	090
43865		A	REVISE STOMACH-BOWEL FUSION	20.17	14.11	3.14	37.42	2	090
43870		A	REPAIR STOMACH OPENING	6.91	6.08	1.20	14.19	1	090
43880		A	REPAIR STOMACH-BOWEL FISTULA	19.11	8.69	1.85	29.65	2	090
43885		A	REVISE STOMACH PLACEMENT	10.43	8.05	1.73	20.21	1	090
43999		C	STOMACH SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
44005		A	FREEING OF BOWEL ADHESION	10.68	8.72	1.84	21.24	1	090
44010		A	INCISION OF SMALL BOWEL	9.73	7.28	1.50	18.51	2	090
44015		A	TUBE JEJUNOSTOMY	2.76	3.39	0.47	6.62	2	222
44020		A	EXPLORATION OF SMALL BOWEL	11.26	8.23	1.74	21.23	1	090
44021		A	DECOMPRESS SMALL BOWEL	11.41	7.38	1.56	20.35	2	090
44025		A	INCISION OF LARGE BOWEL	11.66	8.16	1.70	21.52	1	090
44040		A	EXTERIORIZATION OF BOWEL	12.82	10.25	2.21	25.28	1	090
44050		A	REDUCE BOWEL OBSTRUCTION	10.58	8.19	1.73	20.50	1	090
44055		A	CORRECT MALROTATION OF BOWEL	12.56	8.07	1.69	22.32	1	090
44100		A	BIOPSY OF BOWEL	2.12	1.46	0.13	3.71	2	000
44110		A	EXCISION OF BOWEL LESION(S)	9.49	8.09	1.67	19.25	1	090
44111		A	EXCISION OF BOWEL LESION(S)	11.64	10.19	2.25	24.08	1	090
44120		A	REMOVAL OF SMALL INTESTINE	13.87	9.98	2.13	25.98	2	090
44125		A	REMOVAL OF SMALL INTESTINE	13.87	11.33	2.41	27.61	1	090
44130		A	BOWEL TO BOWEL FUSION	11.69	9.14	1.95	22.78	1	090
44131		N	INTESTINAL BYPASS	0.00	0.00	0.00	0.00		XXX
44140		A	PARTIAL REMOVAL OF COLON	15.39	12.05	2.54	29.98	2	090
44141		A	PARTIAL REMOVAL OF COLON	16.19	12.56	2.70	31.45	2	090
44143		A	PARTIAL REMOVAL OF COLON	15.92	12.98	2.77	31.67	2	090
44144		A	PARTIAL REMOVAL OF COLON	14.69	12.77	2.67	30.13	1	090
44145		A	PARTIAL REMOVAL OF COLON	19.11	14.28	3.00	36.39	2	090
44146		A	PARTIAL REMOVAL OF COLON	18.00	16.10	3.37	37.47	1	090
44147		A	PARTIAL REMOVAL OF COLON	17.68	16.48	3.55	37.71	1	090
44150		A	REMOVAL OF COLON	20.06	15.63	3.34	39.03	1	090
44151		A	REMOVAL OF COLON/ILEOSTOMY	18.92	10.76	2.34	32.02	1	090
44152		A	REMOVAL OF COLON/ILEOSTOMY	21.20	16.27	3.54	41.01	1	090
44153		A	REMOVAL OF COLON/ILEOSTOMY	26.01	14.70	3.11	43.82	1	090
44155		A	REMOVAL OF COLON	20.57	17.55	3.69	41.81	1	090
44156		A	REMOVAL OF COLON/ILEOSTOMY	21.58	12.01	2.65	36.24	1	090
44160		A	REMOVAL OF COLON	14.85	13.12	2.83	30.80	1	090
44300		A	OPEN BOWEL TO SKIN	8.19	6.36	1.36	15.91	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUS	PRACTICE EXPENSE RVUS	MAL- PRACTICE RVUS	TOTAL RVUS	SOURCE OF WORK RVUS	GLOBAL FEE PERIOD
44310		A	ILEOSTOMY/JEJUNOSTOMY	10.61	8.31	1.75	20.67	1	090
44312		A	REVISION OF ILEOSTOMY	5.63	3.24	0.48	9.35	1	090
44314		A	REVISION OF ILEOSTOMY	10.30	7.04	1.28	18.62	1	090
44316		A	DEVISE BOWEL POUCH	14.32	10.16	1.51	25.99	1	090
44320		A	COLOSTOMY	8.92	7.86	1.66	18.44	2	090
44322		A	COLOSTOMY WITH BIOPSIES	10.86	9.56	1.98	22.40	1	090
44340		A	REVISION OF COLOSTOMY	5.18	1.77	0.36	7.31	1	090
44345		A	REVISION OF COLOSTOMY	10.58	5.09	1.08	16.75	1	090
44346		A	REVISION OF COLOSTOMY	11.73	7.01	1.46	20.20	1	090
44360		A	SMALL BOWEL ENDOSCOPY	3.58	4.08	0.33	7.99	2	000
44361		A	SMALL BOWEL ENDOSCOPY, BIOPSY	3.90	5.09	0.35	9.34	2	000
44363		A	SMALL BOWEL ENDOSCOPY	4.64	3.42	0.38	8.44	2	000
44364		A	SMALL BOWEL ENDOSCOPY	4.85	4.98	0.76	10.59	2	000
44366		A	SMALL BOWEL ENDOSCOPY	5.70	6.18	0.47	12.35	2	000
44369		A	SMALL BOWEL ENDOSCOPY	5.70	7.54	0.53	13.77	2	000
44372		A	SMALL BOWEL ENDOSCOPY	5.70	6.14	0.71	12.55	2	000
44373		A	SMALL BOWEL ENDOSCOPY	4.64	5.89	0.53	11.06	2	000
44380		A	SMALL BOWEL ENDOSCOPY	1.59	2.55	0.23	4.37	2	000
44382		A	SMALL BOWEL ENDOSCOPY	1.91	3.43	0.30	5.64	2	000
44385		A	ENDOSCOPY OF BOWEL POUCH	1.91	3.22	0.35	5.48	2	000
44386		A	ENDOSCOPY, BOWEL POUCH, BIOPSY	2.23	1.63	0.15	4.01	2	000
44388		A	COLON ENDOSCOPY	2.97	3.85	0.53	7.35	2	000
44389		A	COLONOSCOPY WITH BIOPSY	3.29	4.54	0.47	8.30	2	000
44390		A	COLONOSCOPY FOR FOREIGN BODY	4.03	2.77	0.29	7.09	2	000
44391		A	COLONOSCOPY FOR BLEEDING	4.56	5.54	0.57	10.67	2	000
44392		A	COLONOSCOPY & POLYPECTOMY	4.25	5.96	0.74	10.95	2	000
44393		A	COLONOSCOPY, LESION REMOVAL	5.09	5.70	0.74	11.53	2	000
44600		A	REPAIR OF BOWEL LESION	10.24	8.06	1.71	20.01	1	090
44605		A	REPAIR OF BOWEL LESION	12.96	9.86	2.13	24.95	1	090
44610		A	REPAIR OF BOWEL LESIONS	13.63	9.58	2.07	25.28	1	090
44620		A	REPAIR BOWEL OPENING	10.17	6.30	1.33	17.80	1	090
44625		A	REPAIR BOWEL OPENING	12.74	10.10	2.14	24.98	2	090
44640		A	REPAIR BOWEL-SKIN FISTULA	14.06	6.89	1.43	22.38	1	090
44650		A	REPAIR BOWEL FISTULA	14.49	7.72	1.54	23.75	1	090
44660		A	REPAIR BOWEL-BLADDER FISTULA	13.86	8.78	1.28	23.92	1	090
44661		A	REPAIR BOWEL-BLADDER FISTULA	16.27	14.70	2.65	33.62	1	090
44680		A	SURGICAL REVISION, INTESTINE	13.08	10.23	2.25	25.56	1	090
44799		C	INTESTINE SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
44800		A	EXCISION OF BOWEL POUCH	10.66	5.52	1.13	17.31	1	090
44820		A	EXCISION OF MESENTERY LESION	9.80	6.11	1.28	17.19	1	090
44850		A	REPAIR OF MESENTERY	9.11	5.89	1.24	16.24	1	090
44899		C	BOWEL SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
44900		A	DRAINAGE OF APPENDIX ABSCESS	8.28	4.52	0.93	13.73	1	090
44950		A	APPENDECTOMY	6.39	5.15	1.06	12.60	1	090
44955		A	APPENDECTOMY	1.61	3.12	0.64	5.37	2	ZZZ
44960		A	APPENDECTOMY	10.31	6.21	1.31	17.83	1	090
45000		A	DRAINAGE OF PELVIC ABSCESS	4.52	1.68	0.25	6.45	1	090
45005		A	DRAINAGE OF RECTAL ABSCESS	2.07	1.36	0.22	3.65	1	010
45020		A	DRAINAGE OF RECTAL ABSCESS	4.64	2.75	0.55	7.94	1	090
45100		A	BIOPSY OF RECTUM	3.57	1.97	0.36	5.90	1	090
45108		A	REMOVAL OF ANORECTAL LESION	4.52	2.81	0.57	7.90	1	090
45110		A	REMOVAL OF RECTUM	22.85	17.20	3.62	43.67	1	090
45111		A	PARTIAL REMOVAL OF RECTUM	15.78	12.41	2.62	30.81	1	090
45112		A	REMOVAL OF RECTUM	25.31	16.92	3.54	45.77	1	090
45114		A	PARTIAL REMOVAL OF RECTUM	22.34	16.21	3.42	41.97	1	090
45116		A	PARTIAL REMOVAL OF RECTUM	20.11	11.35	2.47	33.93	1	090
45120		A	REMOVAL OF RECTUM	16.50	10.34	1.99	28.83	1	090
45121		A	REMOVAL OF RECTUM AND COLON	17.95	11.37	2.12	31.44	1	090
45130		A	EXCISION OF RECTAL PROLAPSE	13.72	9.40	1.88	25.00	1	090
45135		A	EXCISION OF RECTAL PROLAPSE	16.18	16.81	3.69	36.68	1	090
45150		A	EXCISION OF RECTAL STRICTURE	5.54	3.56	0.67	9.77	1	090
45160		A	EXCISION OF RECTAL LESION	13.00	7.86	1.65	22.51	1	090
45170		A	EXCISION OF RECTAL LESION	5.31	4.66	0.96	10.93	2	090
45180		A	REMOVAL OF RECTAL LESION	8.15	5.37	1.11	14.63	1	090
45300		A	PROCTOSIGMOIDOSCOPY	0.74	0.58	0.07	1.39	2	000
45302		A	PROCTOSIGMOIDOSCOPY	0.85	0.77	0.12	1.74	2	000
45303		A	PROCTOSIGMOIDOSCOPY	0.53	0.83	0.12	1.48	2	000
45305		A	PROCTOSIGMOIDOSCOPY; BIOPSY	1.06	0.88	0.14	2.08	2	000

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
45307		A	PROCTOSIGMOIDOSCOPY	1.80	1.34	0.19	3.33	2	000
45310		A	PROCTOSIGMOIDOSCOPY	2.02	1.19	0.21	3.42	2	000
45315		A	PROCTOSIGMOIDOSCOPY	2.12	1.25	0.19	3.56	2	000
45317		A	PROCTOSIGMOIDOSCOPY	2.34	1.33	0.20	3.87	2	000
45320		A	PROCTOSIGMOIDOSCOPY	2.34	1.96	0.35	4.65	2	000
45321		A	PROCTOSIGMOIDOSCOPY	2.23	1.55	0.28	4.06	2	000
45330		A	SIGMOIDOSCOPY, DIAGNOSTIC	1.01	1.39	0.12	2.52	2	000
45331		A	SIGMOIDOSCOPY AND BIOPSY	1.33	1.83	0.15	3.31	2	000
45332		A	SIGMOIDOSCOPY	2.07	1.85	0.16	4.08	2	000
45333		A	SIGMOIDOSCOPY & POLYPECTOMY	2.28	2.36	0.27	4.91	2	000
45334		A	SIGMOIDOSCOPY FOR BLEEDING	2.60	2.86	0.24	5.70	2	000
45336		A	SIGMOIDOSCOPY, LESION REMOVAL	2.60	3.42	0.32	6.34	2	000
45337		A	SIGMOIDOSCOPY, DECOMPRESSION	2.49	3.59	0.40	6.48	2	000
45355		A	SURGICAL COLONOSCOPY	3.71	1.23	0.10	5.04	2	000
45378		A	DIAGNOSTIC COLONOSCOPY	3.71	4.36	0.41	8.48	2	000
45379		A	COLONOSCOPY	4.78	5.62	0.48	10.88	2	000
45380		A	COLONOSCOPY AND BIOPSY	4.03	5.04	0.42	9.49	2	000
45382		A	COLONOSCOPY, CONTROL BLEEDING	5.31	6.19	0.43	11.93	2	000
45383		A	COLONOSCOPY, LESION REMOVAL	5.31	6.24	0.54	12.09	2	000
45385		A	COLONOSCOPY, LESION REMOVAL	4.78	7.06	0.62	12.46	2	000
45500		A	REPAIR OF RECTUM	6.94	6.27	1.28	14.49	1	090
45505		A	REPAIR OF RECTUM	5.83	6.62	1.30	13.75	1	090
45520		A	TREATMENT OF RECTAL PROLAPSE	0.59	0.65	0.10	1.34	2	000
45540		A	CORRECT RECTAL PROLAPSE	12.62	10.42	2.21	25.25	1	090
45541		A	CORRECT RECTAL PROLAPSE	10.32	10.72	2.15	23.19	1	090
45550		A	REPAIR RECTUM; REMOVE SIGMOID	14.10	12.11	2.51	28.72	1	090
45560		A	REPAIR OF RECTOCELE	7.88	5.04	1.03	13.95	1	090
45800		A	REPAIR RECTUMBLADDER FISTULA	13.43	10.35	1.53	25.31	1	090
45805		A	REPAIR FISTULA; COLOSTOMY	15.89	12.98	2.52	31.39	1	090
45820		A	REPAIR RECTOURETHRAL FISTULA	14.03	9.46	1.30	24.79	1	090
45825		A	REPAIR FISTULA; COLOSTOMY	16.28	10.40	1.75	28.43	1	090
45900		A	REDUCTION OF RECTAL PROLAPSE	1.77	0.62	0.11	2.50	2	010
45905		A	DILATION OF ANAL SPHINCTER	1.59	0.75	0.12	2.46	2	010
45910		A	DILATION OF RECTAL NARROWING	1.95	0.92	0.13	3.00	1	010
45915		A	REMOVE RECTAL OBSTRUCTION	2.20	0.82	0.09	3.11	2	010
45999		C	RECTUM SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
46000		A	INCISION OF ANAL FISTULA	2.21	1.53	0.27	4.01	2	010
46030		A	REMOVAL OF RECTAL MARKER	1.27	0.42	0.07	1.76	2	010
46040		A	INCISION OF RECTAL ABSCESS	5.16	1.78	0.35	7.29	1	090
46045		A	INCISION OF RECTAL ABSCESS	4.11	1.94	0.40	6.45	1	090
46050		A	INCISION OF ANAL ABSCESS	1.20	0.64	0.11	1.95	2	010
46060		A	INCISION OF RECTAL ABSCESS	5.31	5.64	1.17	12.12	1	090
46070		A	INCISION OF ANAL SEPTUM	2.78	1.45	0.34	4.57	1	090
46080		A	INCISION OF ANAL SPHINCTER	2.48	2.24	0.45	5.17	2	010
46083		A	INCISE EXTERNAL HEMORRHOID	1.42	0.67	0.08	2.17	1	010
46200		A	REMOVAL OF ANAL FISSURE	3.18	3.47	0.70	7.35	2	090
46210		A	REMOVAL OF ANAL CRYPT	2.65	0.81	0.14	3.60	2	090
46211		A	REMOVAL OF ANAL CRYPTS	4.29	2.01	0.40	6.70	1	090
46220		A	REMOVAL OF ANAL TAB	1.59	0.67	0.12	2.38	2	010
46221		A	LIGATION OF HEMORRHOID(S)	1.46	0.70	0.14	2.30	1	010
46230		A	REMOVAL OF ANAL TABS	2.65	0.87	0.12	3.64	2	010
46250		A	HEMORRHOIDECTOMY	4.53	2.99	0.56	8.08	1	090
46255		A	HEMORRHOIDECTOMY	5.21	4.97	0.89	11.07	1	090
46257		A	REMOVE HEMORRHOIDS & FISSURE	6.19	5.51	1.13	12.83	1	090
46258		A	REMOVE HEMORRHOIDS & FISTULA	6.59	6.19	1.29	14.07	1	090
46260		A	HEMORRHOIDECTOMY	7.06	6.40	1.32	14.78	1	090
46261		A	REMOVE HEMORRHOIDS & FISSURE	6.89	6.97	1.41	15.27	1	090
46262		A	REMOVE HEMORRHOIDS & FISTULA	7.14	7.08	1.47	15.69	1	090
46270		A	REMOVAL OF ANAL FISTULA	3.70	2.73	0.57	7.00	1	090
46275		A	REMOVAL OF ANAL FISTULA	4.59	5.79	1.19	11.57	1	090
46280		A	REMOVAL OF ANAL FISTULA	5.92	6.41	1.31	13.64	1	090
46285		A	REMOVAL OF ANAL FISTULA	4.08	2.41	0.45	6.94	1	090
46320		A	REMOVAL OF HEMORRHOID CLOT	1.67	0.74	0.11	2.52	2	010
46500		A	INJECTION INTO HEMORRHOIDS	1.61	0.33	0.06	2.00	2	010
46600		A	DIAGNOSTIC ANOSCOPY	0.53	0.29	0.03	0.85	2	000
46602		A	DIAGNOSTIC ANOSCOPY	0.64	0.44	0.04	1.12	2	000
46604		A	ANOSCOPY AND DILATION	1.38	0.39	0.06	1.83	2	000
46606		A	ANOSCOPY AND BIOPSY	0.85	0.37	0.06	1.28	2	000

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPDS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
46608		A	ANOSCOPY; REMOVE FOREIGN BODY	1.59	1.12	0.12	2.83	2	000
46610		A	ANOSCOPY; REMOVE LESION	1.59	0.90	0.15	2.64	2	000
46612		A	ANOSCOPY; REMOVE LESIONS	1.70	1.47	0.21	3.38	2	000
46614		A	ANOSCOPY; CONTROL BLEEDING	2.12	1.64	0.26	4.02	2	000
46700		A	REPAIR OF ANAL STRICTURE	6.75	6.47	1.31	14.53	1	090
46705		A	REPAIR OF ANAL STRICTURE	6.73	3.80	0.81	11.34	1	090
46715		A	REPAIR OF ANOVAGINAL FISTULA	8.12	4.55	1.02	13.69	1	090
46716		A	REPAIR OF ANOVAGINAL FISTULA	8.87	5.49	1.16	15.52	1	090
46730		A	CONSTRUCTION OF ABSENT ANUS	13.16	8.87	1.27	23.30	1	090
46735		A	CONSTRUCTION OF ABSENT ANUS	15.41	8.06	1.88	25.35	1	090
46740		A	CONSTRUCTION OF ABSENT ANUS	15.22	9.13	1.53	25.88	1	090
46750		A	REPAIR OF ANAL SPHINCTER	7.75	6.33	1.29	15.37	1	090
46751		A	REPAIR OF ANAL SPHINCTER	8.20	4.29	1.00	13.49	1	090
46753		A	RECONSTRUCTION OF ANUS	6.37	5.15	1.07	12.59	1	090
46754		A	REMOVAL OF SUTURE FROM ANUS	1.59	1.56	0.31	3.46	2	010
46760		A	REPAIR OF ANAL SPHINCTER	11.18	7.17	1.49	19.84	1	090
46761		A	REPAIR OF ANAL SPHINCTER	10.71	7.20	1.43	19.34	1	090
46762		A	IMPLANT ARTIFICIAL SPHINCTER	9.75	6.03	1.28	17.06	1	090
46900		A	DESTRUCTION, ANAL LESION(S)	1.90	0.41	0.06	2.37	2	010
46910		A	DESTRUCTION, ANAL LESION(S)	1.90	0.68	0.08	2.66	2	010
46916		A	CRYOSURGERY, ANAL LESION(S)	1.90	0.71	0.06	2.67	2	010
46917		A	LASER SURGERY, ANAL LESION(S)	1.90	2.05	0.32	4.27	2	010
46922		A	EXCISION OF ANAL LESION(S)	1.90	1.35	0.24	3.49	2	010
46924		A	DESTRUCTION, ANAL LESION(S)	2.86	2.69	0.49	6.04	2	010
46934		A	DESTRUCTION OF HEMORRHOIDS	4.04	1.26	0.17	5.47	1	090
46935		A	DESTRUCTION OF HEMORRHOIDS	2.53	1.71	0.23	4.47	1	010
46936		A	DESTRUCTION OF HEMORRHOIDS	4.40	2.42	0.25	7.07	1	090
46937		A	CRYOTHERAPY OF RECTAL LESION	2.81	2.48	0.47	5.76	1	010
46938		A	CRYOTHERAPY OF RECTAL LESION	4.66	2.63	0.56	7.85	1	090
46940		A	TREATMENT OF ANAL FISSURE	2.42	0.55	0.09	3.06	1	010
46942		A	TREATMENT OF ANAL FISSURE	2.12	0.49	0.08	2.69	2	010
46945		A	LIGATION OF HEMORRHOIDS	3.22	0.67	0.12	4.01	1	090
46946		A	LIGATION OF HEMORRHOIDS	4.25	0.99	0.18	5.42	2	090
46999		C	ANUS SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
47000		A	NEEDLE BIOPSY OF LIVER	2.66	1.48	0.13	4.27	2	010
47001		A	NEEDLE BIOPSY OF LIVER	2.01	1.43	0.09	3.53	2	222
47010		A	DRAINAGE OF LIVER LESION	9.23	7.12	1.18	17.53	2	090
47100		A	WEDGE BIOPSY OF LIVER	7.12	3.47	0.71	11.30	1	090
47120		A	PARTIAL REMOVAL OF LIVER	25.12	12.64	2.61	40.37	1	090
47122		A	EXTENSIVE REMOVAL OF LIVER	27.99	18.53	3.79	50.31	1	090
47125		A	PARTIAL REMOVAL OF LIVER	22.79	18.36	3.81	44.96	1	090
47130		A	PARTIAL REMOVAL OF LIVER	26.94	20.22	4.09	51.25	1	090
47133		E	REMOVAL OF DONOR LIVER	0.00	0.00	0.00	0.00		000
47135		C	TRANSPLANTATION OF LIVER	0.00	0.00	0.00	0.00		090
47300		A	SURGERY FOR LIVER LESION	9.23	8.09	1.68	19.00	1	090
47350		A	REPAIR LIVER WOUND	11.90	7.86	1.57	21.33	1	090
47355		A	REPAIR LIVER WOUND	12.84	7.57	1.42	21.83	1	090
47360		A	REPAIR LIVER WOUND	16.16	11.52	2.29	29.97	1	090
47399		C	LIVER SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
47400		A	INCISION OF LIVER DUCT	19.91	8.98	1.44	30.33	1	090
47420		A	INCISION OF BILE DUCT	13.93	10.00	2.10	26.03	1	090
47425		A	INCISION OF BILE DUCT	15.58	12.34	2.58	30.50	2	090
47440		A	INCISION OF BILE DUCT	19.29	11.06	2.32	32.67	1	090
47460		A	INCISE BILE DUCT SPHINCTER	15.18	16.38	1.91	33.47	1	090
47480		A	INCISION OF GALLBLADDER	8.49	8.00	1.68	18.17	2	090
47490		A	INCISION OF GALLBLADDER	6.37	3.76	0.39	10.52	2	090
47500		A	INJECTION FOR LIVER X-RAYS	2.07	1.59	0.14	3.80	2	222
47510		A	INSERT CATHETER, BILE DUCT	6.37	3.02	0.26	9.65	2	222
47511		A	INSERT BILE DUCT DRAIN	7.43	4.63	0.37	12.43	2	222
47525		A	CHANGE BILE DUCT CATHETER	2.20	1.68	0.16	4.04	1	010
47530		A	REVISE, REINSERT BILE TUBE	4.09	1.59	0.20	5.88	1	090
47550		A	BILE DUCT ENDOSCOPY	3.18	1.65	0.36	5.19	2	000
47552		A	BILIARY ENDOSCOPY, THRU SKIN	6.37	1.44	0.22	8.03	2	000
47553		A	BILIARY ENDOSCOPY, THRU SKIN	6.69	4.00	0.66	11.35	2	000
47554		A	BILIARY ENDOSCOPY, THRU SKIN	9.55	4.13	0.71	14.39	2	000
47555		A	BILIARY ENDOSCOPY, THRU SKIN	7.96	2.77	0.31	11.04	2	000
47556		A	BILIARY ENDOSCOPY, THRU SKIN	9.02	6.84	0.80	16.66	2	000
47600		A	REMOVAL OF GALLBLADDER	9.73	7.93	1.67	19.33	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCCPS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
47605		A	REMOVAL OF GALLBLADDER	11.01	8.58	1.84	21.43	1	090
47610		A	REMOVAL OF GALLBLADDER	13.45	9.86	2.11	25.42	1	090
47612		A	REMOVAL OF GALLBLADDER	15.54	15.00	3.21	33.75	1	090
47620		A	REMOVAL OF GALLBLADDER	16.64	11.83	2.49	30.96	1	090
47630		A	REMOVE BILE DUCT STONE	7.64	3.95	0.42	12.01	1	090
47700		A	EXPLORATION OF BILE DUCTS	14.48	8.03	1.67	24.18	1	090
47701		A	BILE DUCT REVISION	16.55	8.65	2.01	27.21	1	090
47710		A	EXCISION OF BILE DUCT TUMOR	19.43	12.70	2.59	34.72	1	090
47715		A	EXCISION OF BILE DUCT CYST	15.27	8.66	1.80	25.73	1	090
47716		A	FUSION OF BILE DUCT CYST	13.21	6.91	1.61	21.73	1	090
47720		A	FUSE GALLBLADDER & BOWEL	12.54	9.65	2.04	24.23	1	090
47721		A	FUSE UPPER GI STRUCTURES	15.18	12.03	2.60	29.81	1	090
47740		A	FUSE GALLBLADDER & BOWEL	14.68	10.76	2.25	27.69	1	090
47760		A	FUSE BILE DUCTS AND BOWEL	17.02	12.23	2.66	31.91	1	090
47765		A	FUSE LIVER DUCTS & BOWEL	20.06	15.39	3.13	38.58	1	090
47780		A	FUSE BILE DUCTS AND BOWEL	17.68	13.77	2.88	34.33	1	090
47800		A	RECONSTRUCTION OF BILE DUCTS	18.67	13.94	2.56	35.17	1	090
47801		A	PLACEMENT, BILE DUCT SUPPORT	11.89	5.77	0.85	18.51	1	090
47802		A	FUSE LIVER DUCT & INTESTINE	16.87	9.51	1.84	28.22	1	090
47999		C	BILE TRACT SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
48000		A	DRAINAGE OF ABDOMEN	12.68	7.43	1.48	21.59	1	090
48020		A	REMOVAL OF PANCREATIC STONE	13.67	7.15	1.66	22.48	1	090
48100		A	BIOPSY OF PANCREAS	10.74	4.44	0.83	16.01	1	090
48102		A	NEEDLE BIOPSY, PANCREAS	4.67	2.54	0.26	7.47	2	010
48120		A	REMOVAL OF PANCREAS LESION	13.48	10.25	2.18	25.91	1	090
48140		A	PARTIAL REMOVAL OF PANCREAS	17.18	14.01	2.98	34.17	1	090
48145		A	PARTIAL REMOVAL OF PANCREAS	20.11	10.91	2.40	33.42	1	090
48148		A	REMOVAL OF PANCREATIC DUCT	15.18	8.67	1.77	25.62	2	090
48150		A	PARTIAL REMOVAL OF PANCREAS	31.84	23.75	5.00	60.59	2	090
48151		A	PARTIAL REMOVAL OF PANCREAS	19.52	11.14	2.32	32.98	1	090
48155		A	REMOVAL OF PANCREAS	20.48	21.50	4.49	46.47	1	090
48160		N	PANCREAS REMOVAL, TRANSPLANT	0.00	0.00	0.00	0.00		XXX
48180		A	FUSE PANCREAS AND BOWEL	18.80	13.28	2.78	34.86	1	090
48500		A	SURGERY OF PANCREAS CYST	12.68	8.98	1.75	23.41	1	090
48510		A	DRAIN PANCREATIC PSEUDOCYST	11.82	7.94	1.52	21.28	1	090
48520		A	FUSE PANCREAS CYST AND BOWEL	13.66	11.91	2.56	28.13	1	090
48540		A	FUSE PANCREAS CYST AND BOWEL	16.62	13.34	2.80	32.76	1	090
48999		C	PANCREAS SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
49000		A	EXPLORATION OF ABDOMEN	9.47	7.16	1.48	18.11	1	090
49002		A	REOPENING OF ABDOMEN	9.91	6.38	1.28	17.57	1	090
49010		A	EXPLORATION BEHIND ABDOMEN	11.79	7.32	1.38	20.49	1	090
49020		A	DRAIN ABDOMINAL ABSCESS	9.55	5.07	0.96	15.58	2	090
49040		A	DRAIN ABDOMINAL ABSCESS	9.22	6.89	1.34	17.45	1	090
49060		A	DRAIN ABDOMINAL ABSCESS	11.12	5.83	1.06	18.01	1	090
49080		A	PUNCTURE, PERITONEAL CAVITY	1.42	0.92	0.08	2.42	2	000
49081		A	REMOVAL OF ABDOMINAL FLUID	1.33	0.79	0.07	2.19	2	000
49085		A	REMOVE ABDOMEN FOREIGN BODY	8.34	3.65	0.71	12.70	1	090
49180		A	BIOPSY, ABDOMINAL MASS	1.57	1.91	0.21	3.69	2	000
49200		A	REMOVAL OF ABDOMINAL LESION	9.68	8.83	1.79	20.30	1	090
49201		A	REMOVAL OF ABDOMINAL LESION	14.33	12.74	2.63	29.70	1	090
49215		A	EXCISE SACRAL SPINE TUMOR	12.27	8.95	1.68	22.90	1	090
49220		A	MULTIPLE SURGERY, ABDOMEN	14.39	12.96	2.66	30.01	1	090
49250		A	EXCISION OF UMBILICUS	7.82	4.76	1.01	13.59	1	090
49255		A	REMOVAL OF OMENTUM	4.25	5.70	1.21	11.16	2	090
49300		A	PERITONEOSCOPY	4.25	4.00	0.45	8.70	2	000
49301		A	PERITONEOSCOPY WITH BIOPSY	4.56	5.19	0.52	10.27	2	000
49302		A	PERITONEOSCOPY WITH X-RAY	4.25	2.92	0.20	7.37	2	000
49303		A	PERITONEOSCOPY, XRAY & BIOPSY	4.56	3.42	0.38	8.36	2	000
49310		A	LAPAROSCOPIC CHOLECYSTECTOMY	9.73	7.38	0.86	17.97	2	090
49311		A	LAPAROSCOPIC CHOLECYSTECTOMY	11.01	8.35	0.97	20.33	2	090
49400		A	AIR INJECTION INTO ABDOMEN	1.98	1.23	0.18	3.39	2	000
49401		A	AIR INJECTION INTO ABDOMEN	1.75	1.08	0.16	2.99	2	000
49420		A	INSERT ABDOMINAL DRAIN	2.34	1.67	0.21	4.22	2	000
49421		A	INSERT ABDOMINAL DRAIN	5.14	4.37	0.85	10.36	1	090
49425		A	INSERT ABDOMEN-VEIN DRAIN	10.77	8.93	1.87	21.57	1	090
49426		A	REVISE ABDOMEN-VEIN SHUNT	9.03	5.68	1.12	15.83	1	090
49500		A	REPAIR INGUINAL HERNIA	3.68	5.26	1.00	9.94	1	090
49505		A	REPAIR INGUINAL HERNIA	5.08	4.75	0.99	10.82	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
49510		A	REPAIR HERNIA, REMOVE TESTIS	6.91	5.51	1.10	13.52	1	090
49515		A	REPAIR INGUINAL HERNIA	6.19	5.52	1.09	12.80	1	090
49520		A	REREPAIR INGUINAL HERNIA	6.97	5.50	1.16	13.63	1	090
49525		A	REPAIR INGUINAL HERNIA	6.50	5.84	1.22	13.56	1	090
49530		A	REPAIR INCARCERATED HERNIA	7.21	5.26	1.12	13.59	1	090
49535		A	REPAIR STRANGULATED HERNIA	10.15	5.80	1.24	17.19	1	090
49540		A	REPAIR LUMBAR HERNIA	8.34	5.48	1.17	14.99	1	090
49550		A	REPAIR FEMORAL HERNIA	4.64	4.85	1.02	10.51	1	090
49552		A	REPAIR FEMORAL HERNIA	6.67	6.33	1.33	14.33	1	090
49555		A	REPAIR FEMORAL HERNIA	7.68	6.40	1.33	15.41	1	090
49560		A	REPAIR ABDOMINAL HERNIA	8.05	5.96	1.25	15.26	1	090
49565		A	REREPAIR ABDOMINAL HERNIA	8.79	6.76	1.43	16.98	1	090
49570		A	REPAIR EPIGASTRIC HERNIA	4.70	4.62	0.96	10.28	1	090
49575		A	REPAIR EPIGASTRIC HERNIA	6.76	5.89	1.24	13.89	1	090
49580		A	REPAIR UMBILICAL HERNIA	4.26	4.85	0.99	10.10	1	090
49581		A	REPAIR UMBILICAL HERNIA	5.21	4.65	0.96	10.82	1	090
49590		A	REPAIR ABDOMINAL HERNIA	6.90	5.94	1.29	14.13	1	090
49600		A	REPAIR UMBILICAL LESION	7.46	5.54	0.81	13.81	1	090
49605		A	REPAIR UMBILICAL LESION	11.36	9.03	1.86	22.25	1	090
49606		A	REPAIR UMBILICAL LESION	10.60	8.75	1.01	20.36	1	090
49610		A	REPAIR UMBILICAL LESION	10.36	5.77	1.34	17.47	1	090
49611		A	REPAIR UMBILICAL LESION	8.69	9.48	0.62	18.79	1	090
49900		A	REPAIR OF ABDOMINAL WALL	4.78	3.86	0.79	9.43	2	090
49999		C	ABDOMEN SURGERY PROCEDURE	0.00	0.00	0.00	0.00	YYY	YYY
50010		A	EXPLORATION OF KIDNEY	10.61	10.07	1.19	21.87	2	090
50020		A	DRAINAGE OF KIDNEY ABSCESS	13.08	7.17	0.89	21.14	1	090
50040		A	DRAINAGE OF KIDNEY	14.53	7.57	0.66	22.76	1	090
50045		A	EXPLORATION OF KIDNEY	15.25	10.34	0.94	26.53	1	090
50060		A	REMOVAL OF KIDNEY STONE	18.97	12.91	1.28	33.16	1	090
50065		A	INCISION OF KIDNEY	20.68	14.68	1.43	36.79	1	090
50070		A	INCISION OF KIDNEY	20.17	13.56	1.43	35.16	1	090
50075		A	REMOVAL OF KIDNEY STONE	25.35	17.77	1.71	44.83	1	090
50080		A	REMOVAL OF KIDNEY STONE	14.74	12.86	1.21	28.81	1	090
50081		A	REMOVAL OF KIDNEY STONE	21.68	15.77	1.52	38.97	1	090
50100		A	REVISE KIDNEY BLOOD VESSELS	15.92	10.90	1.42	28.24	2	090
50120		A	EXPLORATION OF KIDNEY	15.81	11.50	1.31	28.62	1	090
50125		A	EXPLORE AND DRAIN KIDNEY	16.45	11.54	1.11	29.10	2	090
50130		A	REMOVAL OF KIDNEY STONE	16.98	13.49	1.33	31.80	2	090
50135		A	EXPLORATION OF KIDNEY	19.11	17.97	1.72	38.80	2	090
50200		A	BIOPSY OF KIDNEY	2.78	2.75	0.23	5.76	2	000
50205		A	BIOPSY OF KIDNEY	13.37	5.95	0.73	20.05	1	090
50220		A	REMOVAL OF KIDNEY	16.84	14.03	1.51	32.38	1	090
50225		A	REMOVAL OF KIDNEY	19.95	17.40	1.79	39.14	1	090
50230		A	REMOVAL OF KIDNEY	21.66	19.38	1.93	42.97	1	090
50234		A	REMOVAL OF KIDNEY & URETER	22.24	17.55	1.74	41.53	1	090
50236		A	REMOVAL OF KIDNEY & URETER	24.58	18.70	1.83	45.11	1	090
50240		A	PARTIAL REMOVAL OF KIDNEY	21.33	16.86	1.79	39.98	1	090
50280		A	REMOVAL OF KIDNEY LESION	15.41	11.44	1.22	28.07	1	090
50290		A	REMOVAL OF KIDNEY LESION	14.42	9.35	1.25	25.02	1	090
50300		E	REMOVAL OF DONOR KIDNEY	0.00	0.00	0.00	0.00		000
50320		E	REMOVAL OF DONOR KIDNEY	0.00	0.00	0.00	0.00		000
50340		A	REMOVAL OF KIDNEY	11.30	13.17	2.36	26.83	1	090
50360		A	TRANSPLANTATION OF KIDNEY	26.53	25.77	4.47	56.77	2	090
50365		A	TRANSPLANTATION OF KIDNEY	31.84	32.36	4.09	68.29	2	090
50370		A	REMOVE TRANSPLANTED KIDNEY	11.71	11.67	2.03	25.41	1	090
50380		A	REIMPLANTATION OF KIDNEY	17.37	10.66	1.80	29.83	1	090
50390		A	DRAINAGE OF KIDNEY LESION	3.42	1.78	0.15	5.35	2	222
50392		A	INSERT KIDNEY DRAIN	4.25	2.49	0.21	6.95	2	222
50393		A	INSERT URETERAL TUBE	4.79	3.17	0.27	8.23	1	222
50394		A	INJECTION FOR KIDNEY X-RAY	2.17	0.59	0.05	2.81	1	222
50395		A	CREATE PASSAGE TO KIDNEY	5.43	3.51	0.30	9.24	1	222
50396		A	MEASURE KIDNEY PRESSURE	2.20	1.53	0.14	3.87	1	222
50398		A	CHANGE KIDNEY TUBE	1.54	0.57	0.05	2.16	2	222
50400		A	REVISION OF KIDNEY/URETER	19.04	14.39	1.44	34.87	1	090
50405		A	REVISION OF KIDNEY/URETER	23.66	18.22	1.83	43.71	1	090
50500		A	REPAIR OF KIDNEY WOUND	19.25	13.14	1.73	34.12	1	090
50520		A	CLOSE KIDNEY-SKIN FISTULA	16.79	10.90	1.58	29.27	1	090
50525		A	REPAIR RENAL-ABDOMEN FISTULA	21.69	13.29	2.10	37.08	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUS	PRACTICE EXPENSE RVUS	MAL- PRACTICE RVUS	TOTAL RVUS	SOURCE OF WORK RVUS	GLOBAL FEE PERIOD
50526		A	REPAIR RENAL-ABDOMEN FISTULA	23.35	7.79	2.45	33.59	2	090
50540		A	REVISION OF HORSESHOE KIDNEY	20.17	14.13	1.63	35.93	1	090
50551		A	KIDNEY ENDOSCOPY	5.89	2.30	0.22	8.41	1	000
50553		A	KIDNEY ENDOSCOPY	6.32	1.75	0.17	8.24	1	000
50555		A	KIDNEY ENDOSCOPY & BIOPSY	6.88	4.95	0.48	12.31	1	000
50557		A	KIDNEY ENDOSCOPY & TREATMENT	6.97	4.96	0.52	12.45	1	000
50559		A	RENAL ENDOSCOPY; RADIOTRACER	7.15	1.41	0.14	8.70	1	000
50561		A	KIDNEY ENDOSCOPY & TREATMENT	7.99	5.40	0.52	13.91	1	000
50570		A	KIDNEY ENDOSCOPY	10.06	1.53	0.14	11.73	1	000
50572		A	KIDNEY ENDOSCOPY	10.91	7.64	0.79	19.34	1	000
50574		A	KIDNEY ENDOSCOPY & BIOPSY	11.61	7.46	0.68	19.75	1	000
50576		A	KIDNEY ENDOSCOPY & TREATMENT	11.58	9.17	0.81	21.56	1	000
50578		A	RENAL ENDOSCOPY; RADIOTRACER	11.96	3.99	1.26	17.21	1	000
50580		A	KIDNEY ENDOSCOPY & TREATMENT	12.50	3.77	0.36	16.63	1	000
50590		A	FRAGMENTING OF KIDNEY STONE	10.14	10.65	1.02	21.81	1	090
50600		A	EXPLORATION OF URETER	15.57	10.21	1.06	26.84	1	090
50605		A	INSERT URETERAL SUPPORT	15.17	6.44	0.64	22.25	1	090
50610		A	REMOVAL OF URETER STONE	15.67	12.41	1.23	29.31	1	090
50620		A	REMOVAL OF URETER STONE	14.94	12.11	1.22	28.27	1	090
50630		A	REMOVAL OF URETER STONE	14.71	13.39	1.32	29.42	1	090
50650		A	REMOVAL OF URETER	17.25	12.71	1.28	31.24	1	090
50660		A	REMOVAL OF URETER	19.44	13.17	1.62	34.23	1	090
50684		A	INJECTION FOR URETER X-RAY	0.80	0.52	0.05	1.37	2	ZZZ
50686		A	MEASURE URETER PRESSURE	1.59	0.38	0.04	2.01	2	ZZZ
50688		A	CHANGE OF URETER TUBE	1.20	0.41	0.04	1.65	2	010
50690		A	INJECTION FOR URETER X-RAY	1.22	0.33	0.03	1.58	1	ZZZ
50700		A	REVISION OF URETER	14.86	13.25	1.36	29.47	2	090
50715		A	RELEASE OF URETER	16.98	11.85	1.57	30.40	2	090
50722		A	RELEASE OF URETER	15.92	10.87	2.08	28.87	2	090
50725		A	RELEASE/REVISE URETER	18.04	12.69	1.84	32.57	2	090
50740		A	FUSION OF URETER & KIDNEY	18.04	11.77	1.60	31.41	2	090
50750		A	FUSION OF URETER & KIDNEY	19.11	14.80	1.33	35.24	2	090
50760		A	FUSION OF URETERS	18.04	14.19	1.56	33.79	2	090
50770		A	SPlicing OF URETERS	19.11	16.05	1.61	36.77	2	090
50780		A	REIMPLANT URETER IN BLADDER	18.04	14.51	1.54	34.09	2	090
50785		A	REIMPLANT URETER IN BLADDER	20.17	16.25	1.89	38.31	2	090
50800		A	IMPLANT URETER IN BOWEL	13.80	15.46	1.59	30.85	2	090
50810		A	FUSION OF URETER & BOWEL	19.11	13.25	1.84	34.20	2	090
50815		A	URINE SHUNT TO BOWEL	19.11	20.82	2.90	42.83	2	090
50820		A	CONSTRUCT BOWEL BLADDER	21.23	19.99	2.63	43.85	2	090
50825		A	CONSTRUCT BOWEL BLADDER	27.60	32.19	3.51	63.30	2	090
50830		A	REVISE URINE FLOW	30.87	22.05	2.40	55.32	1	090
50840		A	REPLACE URETER BY BOWEL	19.11	14.04	1.43	34.58	2	090
50860		A	TRANSPLANT URETER TO SKIN	14.75	11.51	1.22	27.48	1	090
50900		A	REPAIR OF URETER	13.26	10.51	1.21	24.98	1	090
50920		A	CLOSURE URETER/SKIN FISTULA	13.94	10.04	1.04	25.02	1	090
50930		A	CLOSURE URETER/BOWEL FISTULA	18.56	13.18	1.29	33.03	1	090
50940		A	RELEASE OF URETER	14.19	10.43	1.00	25.62	1	090
50951		A	ENDOSCOPY OF URETER	6.15	1.76	0.17	8.08	1	000
50953		A	ENDOSCOPY OF URETER	6.57	1.75	0.16	8.48	1	000
50955		A	URETER ENDOSCOPY & BIOPSY	7.12	2.68	0.26	10.06	1	000
50957		A	URETER ENDOSCOPY & TREATMENT	7.16	2.63	0.26	10.05	1	000
50959		A	URETER ENDOSCOPY & TRACER	4.64	3.56	0.30	8.50	1	000
50961		A	URETER ENDOSCOPY & TREATMENT	6.38	2.76	0.27	9.41	1	000
50970		A	URETER ENDOSCOPY	7.53	5.45	0.56	13.54	1	000
50972		A	URETER ENDOSCOPY & CATHETER	7.26	5.27	0.52	13.05	1	000
50974		A	URETER ENDOSCOPY & BIOPSY	9.66	7.39	0.69	17.74	1	000
50976		A	URETER ENDOSCOPY & TREATMENT	9.52	6.76	0.66	16.94	1	000
50978		A	URETER ENDOSCOPY & TRACER	5.38	4.27	0.51	10.16	1	000
50980		A	URETER ENDOSCOPY & TREATMENT	7.22	3.29	0.31	10.82	1	000
51000		A	DRAINAGE OF BLADDER	0.82	0.51	0.05	1.38	2	000
51005		A	DRAINAGE OF BLADDER	1.07	0.49	0.04	1.60	2	000
51010		A	DRAINAGE OF BLADDER	2.67	1.02	0.11	3.80	1	010
51020		A	INCISE & TREAT BLADDER	6.37	7.22	0.75	14.34	2	090
51030		A	INCISE & TREAT BLADDER	6.37	4.77	0.45	11.59	2	090
51040		A	INCISE & DRAIN BLADDER	4.30	7.71	0.79	12.80	1	090
51045		A	INCISE BLADDER, DRAIN URETER	6.37	5.24	0.54	12.15	2	090
51050		A	REMOVAL OF BLADDER STONE	6.37	7.50	0.74	14.61	2	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
51060		A	REMOVAL OF URETER STONE	8.49	12.83	1.26	22.58	2	090
51065		A	REMOVAL OF URETER STONE	8.49	7.46	0.75	16.70	2	090
51080		A	DRAINAGE OF BLADDER ABSCESS	5.70	5.46	0.61	11.77	2	090
51500		A	REMOVAL OF BLADDER CYST	10.06	7.23	1.28	18.57	1	090
51520		A	REMOVAL OF BLADDER LESION	9.16	8.98	0.92	19.06	1	090
51525		A	REMOVAL OF BLADDER LESION	13.46	11.24	1.11	25.81	1	090
51530		A	REMOVAL OF BLADDER LESION	11.93	9.74	1.07	22.74	1	090
51535		A	REPAIR OF URETER LESION	12.13	8.10	1.20	21.43	1	090
51550		A	PARTIAL REMOVAL OF BLADDER	15.11	11.28	1.23	27.62	1	090
51555		A	PARTIAL REMOVAL OF BLADDER	20.65	12.92	1.38	34.95	1	090
51565		A	REVISE BLADDER & URETER(S)	21.09	16.69	1.76	39.54	1	090
51570		A	REMOVAL OF BLADDER	23.36	16.50	1.71	41.57	1	090
51575		A	REMOVAL OF BLADDER & NODES	29.43	24.09	2.37	55.89	1	090
51580		A	REMOVE BLADDER; REVISE TRACT	29.72	21.03	2.15	52.90	2	090
51585		A	REMOVAL OF BLADDER & NODES	33.96	26.47	2.55	62.98	2	090
51590		A	REMOVE BLADDER; REVISE TRACT	31.84	25.84	2.70	60.38	2	090
51595		A	REMOVE BLADDER; REVISE TRACT	36.09	35.62	3.52	75.23	2	090
51596		A	REMOVE BLADDER, CREATE POUCH	38.21	36.76	3.64	78.61	2	090
51597		A	REMOVAL OF PELVIC STRUCTURES	37.16	32.28	4.55	73.99	1	090
51600		A	INJECTION FOR BLADDER X-RAY	0.93	0.29	0.03	1.25	2	ZZZ
51605		A	PREPARATION FOR BLADDER XRAY	1.18	0.31	0.03	1.52	1	ZZZ
51610		A	INJECTION FOR BLADDER X-RAY	1.68	0.28	0.02	1.98	1	ZZZ
51700		A	IRRIGATION OF BLADDER	0.93	0.23	0.02	1.18	2	ZZZ
51705		A	CHANGE OF BLADDER TUBE	1.04	0.39	0.04	1.47	2	ZZZ
51710		A	CHANGE OF BLADDER TUBE	1.54	0.61	0.06	2.21	2	ZZZ
51720		A	TREATMENT OF BLADDER LESION	2.07	0.48	0.05	2.60	1	ZZZ
51725		A	SIMPLE CYSTOMETROGRAM	1.59	1.06	0.11	2.76	2	ZZZ
51725	TC	A	SIMPLE CYSTOMETROGRAM	0.00	0.39	0.04	0.43		ZZZ
51725	26	A	SIMPLE CYSTOMETROGRAM	1.59	0.67	0.07	2.33	2	ZZZ
51726		A	COMPLEX CYSTOMETROGRAM	1.80	1.41	0.14	3.35	1	ZZZ
51726	TC	A	COMPLEX CYSTOMETROGRAM	0.00	0.56	0.06	0.62		ZZZ
51726	26	A	COMPLEX CYSTOMETROGRAM	1.80	0.85	0.08	2.73	1	ZZZ
51736		A	URINE FLOW MEASUREMENT	0.88	0.47	0.05	1.40	1	ZZZ
51736	TC	A	URINE FLOW MEASUREMENT	0.00	0.20	0.02	0.22		ZZZ
51736	26	A	URINE FLOW MEASUREMENT	0.88	0.27	0.03	1.18	1	ZZZ
51739		A	SOUND RECORD OF URINE STREAM	0.97	0.86	0.09	1.92	1	ZZZ
51739	TC	A	SOUND RECORD OF URINE STREAM	0.00	0.17	0.02	0.19		ZZZ
51739	26	A	SOUND RECORD OF URINE STREAM	0.97	0.69	0.07	1.73	1	ZZZ
51741		A	ELECTRO-UROFLOWMETRY, FIRST	1.66	0.64	0.07	2.37	1	ZZZ
51741	TC	A	ELECTRO-UROFLOWMETRY, FIRST	0.00	0.28	0.03	0.31		ZZZ
51741	26	A	ELECTRO-UROFLOWMETRY, FIRST	1.66	0.36	0.04	2.06	1	ZZZ
51772		A	URETHRA PRESSURE PROFILE	1.70	1.12	0.12	2.94	1	ZZZ
51772	TC	A	URETHRA PRESSURE PROFILE	0.00	0.56	0.06	0.62		ZZZ
51772	26	A	URETHRA PRESSURE PROFILE	1.70	0.56	0.06	2.32	1	ZZZ
51785		A	ANAL/URINARY MUSCLE STUDY	1.62	1.10	0.11	2.83	1	ZZZ
51785	TC	A	ANAL/URINARY MUSCLE STUDY	0.00	0.41	0.04	0.45		ZZZ
51785	26	A	ANAL/URINARY MUSCLE STUDY	1.62	0.69	0.07	2.38	1	ZZZ
51792		A	URINARY REFLEX STUDY	1.15	1.01	0.10	2.26	1	ZZZ
51792	TC	A	URINARY REFLEX STUDY	0.00	0.38	0.04	0.42		ZZZ
51792	26	A	URINARY REFLEX STUDY	1.15	0.63	0.06	1.84	1	ZZZ
51795		A	URINE VOIDING PRESSURE STUDY	1.61	1.02	0.10	2.73	1	ZZZ
51795	TC	A	URINE VOIDING PRESSURE STUDY	0.00	0.41	0.04	0.45		ZZZ
51795	26	A	URINE VOIDING PRESSURE STUDY	1.61	0.61	0.06	2.28	1	ZZZ
51797		A	INTRAABDOMINAL PRESSURE TEST	1.69	0.88	0.08	2.65	1	ZZZ
51797	TC	A	INTRAABDOMINAL PRESSURE TEST	0.00	0.33	0.03	0.36		ZZZ
51797	26	A	INTRAABDOMINAL PRESSURE TEST	1.69	0.55	0.05	2.29	1	ZZZ
51800		A	REVISION OF BLADDER/URETHRA	17.19	12.66	1.55	31.40	1	090
51820		A	REVISION OF URINARY TRACT	17.57	7.79	1.39	26.75	1	090
51840		A	ATTACH BLADDER/URETHRA	10.31	9.71	1.33	21.35	1	090
51841		A	ATTACH BLADDER/URETHRA	12.74	11.60	1.56	25.90	2	090
51845		A	REPAIR BLADDER NECK	8.61	11.28	1.14	21.03	1	090
51860		A	REPAIR OF BLADDER WOUND	11.77	8.02	0.96	20.75	1	090
51865		A	REPAIR OF BLADDER WOUND	14.75	11.55	1.34	27.64	1	090
51880		A	REPAIR OF BLADDER OPENING	7.60	5.24	0.56	13.40	1	090
51900		A	REPAIR BLADDER/VAGINA LESION	12.30	12.28	1.49	26.07	2	090
51920		A	CLOSE BLADDER-UTERUS FISTULA	11.14	7.91	0.77	19.82	2	090
51925		A	HYSTERECTOMY/BLADDER REPAIR	14.86	10.61	2.46	27.93	2	090
51940		C	CORRECTION OF BLADDER DEFECT	0.00	0.00	0.00	0.00		090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPs*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
51960		A	REVISION OF BLADDER & BOWEL	22.29	22.55	2.40	47.24	2	090
51980		A	CONSTRUCT BLADDER OPENING	11.00	7.86	0.79	19.65	1	090
52000		A	CYSTOSCOPY	2.12	1.40	0.14	3.66	2	000
52005		A	CYSTOSCOPY & URETER CATHETER	2.50	2.31	0.23	5.04	1	000
52007		A	CYSTOSCOPY AND BIOPSY	3.18	2.97	0.29	6.44	2	000
52010		A	CYSTOSCOPY & DUCT CATHETER	3.18	2.01	0.21	5.40	2	000
52204		A	CYSTOSCOPY	2.50	2.51	0.25	5.26	2	000
52214		A	CYSTOSCOPY AND TREATMENT	3.91	2.95	0.29	7.15	2	000
52224		A	CYSTOSCOPY AND TREATMENT	3.30	3.06	0.30	6.66	2	000
52234		A	CYSTOSCOPY AND TREATMENT	4.88	4.96	0.48	10.32	2	000
52235		A	CYSTOSCOPY AND TREATMENT	5.74	8.74	0.85	15.33	2	000
52240		A	CYSTOSCOPY AND TREATMENT	8.20	11.22	1.09	20.51	2	000
52250		A	CYSTOSCOPY & RADIOTRACER	4.74	3.01	0.30	8.05	2	000
52260		A	CYSTOSCOPY & TREATMENT	4.12	2.22	0.23	6.57	2	000
52265		A	CYSTOSCOPY & TREATMENT	3.10	1.42	0.14	4.66	2	000
52270		A	CYSTOSCOPY & REVISE URETHRA	4.04	3.66	0.36	8.06	2	000
52275		A	CYSTOSCOPY & REVISE URETHRA	4.95	3.61	0.35	8.91	2	000
52276		A	CYSTOSCOPY AND TREATMENT	4.13	4.82	0.47	9.42	2	000
52277		A	CYSTOSCOPY AND TREATMENT	6.50	5.07	0.50	12.07	2	000
52281		A	CYSTOSCOPY AND TREATMENT	2.95	2.44	0.24	5.63	2	000
52283		A	CYSTOSCOPY AND TREATMENT	3.94	1.59	0.15	5.68	2	000
52285		A	CYSTOSCOPY AND TREATMENT	3.81	3.10	0.31	7.22	2	000
52290		A	CYSTOSCOPY AND TREATMENT	4.83	2.47	0.25	7.55	2	000
52300		A	CYSTOSCOPY AND TREATMENT	5.64	3.66	0.37	9.67	2	000
52305		A	CYSTOSCOPY AND TREATMENT	5.60	3.69	0.36	9.65	2	000
52310		A	CYSTOSCOPY AND TREATMENT	2.96	3.15	0.31	6.42	2	000
52315		A	CYSTOSCOPY AND TREATMENT	5.49	4.29	0.42	10.20	2	000
52317		A	REMOVE BLADDER STONE	7.08	6.52	0.63	14.23	2	000
52318		A	REMOVE BLADDER STONE	9.68	8.31	0.81	18.80	2	000
52320		A	CYSTOSCOPY AND TREATMENT	4.95	5.11	0.50	10.56	2	000
52325		A	CYSTOSCOPY, STONE REMOVAL	6.49	7.39	0.72	14.60	2	000
52330		A	CYSTOSCOPY AND TREATMENT	5.32	3.66	0.36	9.34	2	000
52332		A	CYSTOSCOPY AND TREATMENT	2.98	3.38	0.33	6.69	2	000
52334		A	CREATE PASSAGE TO KIDNEY	5.08	3.51	0.35	8.94	2	000
52335		A	ENDOSCOPY OF URINARY TRACT	6.18	4.94	0.48	11.60	2	000
52336		A	CYSTOSCOPY, STONE REMOVAL	7.25	10.72	1.04	19.01	2	000
52337		A	CYSTOSCOPY, STONE REMOVAL	8.40	11.57	1.13	21.10	2	000
52338		A	CYSTOSCOPY AND TREATMENT	7.74	6.24	0.61	14.59	2	000
52340		A	CYSTOSCOPY AND TREATMENT	8.18	5.43	0.53	14.14	1	090
52450		A	INCISION OF PROSTATE	7.43	5.27	0.52	13.22	2	090
52500		A	REVISION OF BLADDER NECK	8.24	7.84	0.76	16.84	1	090
52510		A	DILATION PROSTATIC URETHRA	6.37	4.52	0.44	11.33	2	090
52601		A	PROSTATECTOMY (TURP)	12.13	12.51	1.22	25.86	1	090
52606		A	CONTROL POSTOP BLEEDING	7.91	3.50	0.34	11.75	1	090
52612		A	PROSTATECTOMY, FIRST STAGE	7.43	10.57	1.04	19.04	2	090
52614		A	PROSTATECTOMY, SECOND STAGE	6.37	7.47	0.72	14.56	2	090
52620		A	REMOVE RESIDUAL PROSTATE	6.37	5.62	0.55	12.54	2	090
52630		A	REMOVE PROSTATE REGROWTH	6.90	12.10	1.18	20.18	2	090
52640		A	RELIEVE BLADDER CONTRACTURE	6.37	6.78	0.66	13.81	2	090
52650		A	PROSTATECTOMY	11.14	7.60	0.81	19.55	1	090
52700		A	DRAINAGE OF PROSTATE ABSCESS	6.65	3.48	0.35	10.48	1	090
53000		A	INCISION OF URETHRA	2.12	1.85	0.17	4.14	2	010
53010		A	INCISION OF URETHRA	3.18	3.71	0.38	7.27	2	090
53020		A	INCISION OF URETHRA	1.86	0.86	0.09	2.81	1	000
53025		A	INCISION OF URETHRA	1.19	0.84	0.08	2.11	1	000
53040		A	DRAINAGE OF URETHRA ABSCESS	6.34	1.94	0.20	8.48	1	090
53060		A	DRAINAGE OF URETHRA ABSCESS	2.72	0.55	0.07	3.34	1	010
53080		A	DRAINAGE OF URINARY LEAKAGE	6.19	4.19	0.47	10.85	1	090
53085		A	DRAINAGE OF URINARY LEAKAGE	10.19	7.12	0.74	18.05	1	090
53200		A	BIOPSY OF URETHRA	2.73	1.15	0.12	4.00	2	000
53210		A	REMOVAL OF URETHRA	12.34	6.99	0.71	20.04	1	090
53215		A	REMOVAL OF URETHRA	15.37	10.53	1.01	26.91	1	090
53220		A	TREATMENT OF URETHRA LESION	6.93	5.02	0.52	12.47	1	090
53230		A	REMOVAL OF URETHRA LESION	9.52	8.36	0.83	18.71	1	090
53235		A	REMOVAL OF URETHRA LESION	10.12	5.30	0.52	15.94	1	090
53240		A	SURGERY FOR URETHRA POUCH	6.36	4.57	0.47	11.40	1	090
53250		A	REMOVAL OF URETHRA GLAND	6.00	4.26	0.42	10.68	1	090
53260		A	TREATMENT OF URETHRA LESION	3.09	1.17	0.16	4.42	1	010

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
53265		A	TREATMENT OF URETHRA LESION	3.23	1.99	0.23	5.45	1	010
53270		A	REMOVAL OF URETHRA GLAND	3.09	0.88	0.19	4.16	1	010
53275		A	REPAIR OF URETHRA DEFECT	4.61	2.50	0.26	7.37	1	010
53400		A	REVISE URETHRA, 1ST STAGE	10.40	7.87	0.80	19.07	1	090
53405		A	REVISE URETHRA, 2ND STAGE	11.96	8.58	0.82	21.36	1	090
53410		A	RECONSTRUCTION OF URETHRA	13.01	9.02	0.88	22.91	1	090
53415		A	RECONSTRUCTION OF URETHRA	16.25	12.51	1.21	29.97	1	090
53420		A	RECONSTRUCT URETHRA, STAGE 1	11.28	11.46	1.10	23.84	1	090
53425		A	RECONSTRUCT URETHRA, STAGE 2	13.46	9.74	0.93	24.13	1	090
53430		A	RECONSTRUCTION OF URETHRA	13.64	7.55	0.80	21.99	1	090
53440		A	CORRECT BLADDER FUNCTION	12.11	13.86	1.47	27.44	1	090
53442		A	REMOVE PERINEAL PROSTHESIS	8.09	6.15	0.71	14.95	1	090
53443		A	RECONSTRUCTION OF URETHRA	17.34	12.16	1.43	30.93	1	090
53445		A	CORRECT URINE FLOW CONTROL	13.87	21.59	2.14	37.60	1	090
53447		A	REMOVE ARTIFICIAL SPHINCTER	13.03	9.65	0.94	23.62	1	090
53449		A	CORRECT ARTIFICIAL SPHINCTER	9.65	8.86	0.86	19.37	1	090
53450		A	REVISION OF URETHRA	6.03	2.89	0.28	9.20	1	090
53460		A	REVISION OF URETHRA	7.06	2.57	0.26	9.89	1	090
53502		A	REPAIR OF URETHRA INJURY	7.60	5.25	0.60	13.45	1	090
53505		A	REPAIR OF URETHRA INJURY	7.60	5.46	0.55	13.61	1	090
53510		A	REPAIR OF URETHRA INJURY	10.09	7.35	0.70	18.14	1	090
53515		A	REPAIR OF URETHRA INJURY	13.39	9.51	0.93	23.83	1	090
53520		A	REPAIR OF URETHRA DEFECT	8.65	6.21	0.60	15.46	1	090
53600		A	DILATE URETHRA STRICTURE	1.28	0.34	0.03	1.65	2	000
53601		A	DILATE URETHRA STRICTURE	1.03	0.30	0.03	1.36	2	000
53605		A	DILATE URETHRA STRICTURE	1.35	0.49	0.05	1.89	2	000
53620		A	DILATE URETHRA STRICTURE	1.71	0.50	0.05	2.26	2	000
53621		A	DILATE URETHRA STRICTURE	1.42	0.39	0.04	1.85	2	000
53640		A	RELIEVE BLADDER RETENTION	1.68	0.61	0.06	2.35	2	000
53660		A	DILATION OF URETHRA	0.75	0.29	0.03	1.07	2	000
53661		A	DILATION OF URETHRA	0.76	0.26	0.03	1.05	2	000
53665		A	DILATION OF URETHRA	0.80	0.37	0.04	1.21	2	000
53670		A	INSERT URINARY CATHETER	0.53	0.23	0.02	0.78	2	ZZZ
53675		A	INSERT URINARY CATHETER	1.55	0.50	0.05	2.10	2	ZZZ
53800		E	URINALYSIS, GLASS TEST	0.00	0.00	0.00	0.00		ZZZ
53899		C	UROLOGY SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
54000		A	SLITTING OF PREPUCE	1.57	0.67	0.07	2.31	1	010
54001		A	SLITTING OF PREPUCE	2.25	0.88	0.09	3.22	1	010
54015		A	DRAIN PENIS LESION	5.44	0.87	0.09	6.40	1	010
54050		A	DESTRUCTION, PENIS LESION(S)	1.25	0.40	0.03	1.68	2	010
54055		A	DESTRUCTION, PENIS LESION(S)	1.25	0.65	0.06	1.96	2	010
54056		A	CRYOSURGERY, PENIS LESION(S)	1.25	0.57	0.04	1.86	2	010
54057		A	LASER SURG, PENIS LESION(S)	1.25	2.14	0.22	3.61	2	010
54060		A	EXCISION OF PENIS LESION(S)	1.97	1.23	0.12	3.32	2	010
54065		A	DESTRUCTION, PENIS LESION(S)	2.50	2.60	0.26	5.36	2	010
54100		A	BIOPSY OF PENIS	2.01	0.69	0.07	2.77	2	000
54105		A	BIOPSY OF PENIS	3.64	1.06	0.11	4.81	2	010
54110		A	TREATMENT OF PENIS LESION	10.18	6.36	0.65	17.19	1	090
54111		A	TREAT PENIS LESION, GRAFT	13.72	9.67	1.02	24.41	1	090
54112		A	TREAT PENIS LESION, GRAFT	15.95	11.42	1.20	28.57	1	090
54115		A	TREATMENT OF PENIS LESION	5.99	4.41	0.46	10.86	1	090
54120		A	PARTIAL REMOVAL OF PENIS	9.73	6.82	0.66	17.21	1	090
54125		A	REMOVAL OF PENIS	13.49	12.18	1.23	26.90	1	090
54130		A	REMOVE PENIS & NODES	19.93	15.45	1.39	36.77	1	090
54135		A	REMOVE PENIS & NODES	26.35	18.71	1.83	46.89	1	090
54150		A	CIRCUMCISION	1.87	0.58	0.05	2.50	1	010
54152		A	CIRCUMCISION	2.39	1.91	0.21	4.51	1	010
54160		A	CIRCUMCISION	2.56	1.75	0.22	4.53	1	010
54161		A	CIRCUMCISION	3.39	2.28	0.24	5.91	1	010
54200		A	TREATMENT OF PENIS LESION	1.06	0.33	0.03	1.42	2	010
54205		A	TREATMENT OF PENIS LESION	7.59	5.39	0.53	13.51	1	090
54220		A	TREATMENT OF PENIS LESION	3.35	1.67	0.17	5.19	1	090
54230		A	PREPARE PENIS STUDY	1.41	1.41	0.13	2.95	2	ZZZ
54235		A	PENILE INJECTION	1.26	0.45	0.04	1.75	1	000
54240		A	PENIS PRESSURE STUDY	2.30	1.07	0.12	3.49	1	000
54240	TC	A	PENIS PRESSURE STUDY	0.00	0.52	0.06	0.58		000
54240	26	A	PENIS PRESSURE STUDY	2.30	0.55	0.06	2.91	1	000
54250		A	TEST PENILE ERECTION/RIGID	2.34	0.87	0.08	3.29	1	000

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCCPS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
54250	TC	A	TEST PENILE ERECTION/RIGID	0.00	0.33	0.03	0.36		000
54250	26	A	TEST PENILE ERECTION/RIGID	2.34	0.54	0.05	2.93	1	000
54300	A	A	REVISION OF PENIS	10.58	7.25	0.92	18.75	1	090
54304	A	A	REVISION OF PENIS	12.78	9.13	0.95	22.86	1	090
54308	A	A	RECONSTRUCTION OF URETHRA	9.33	6.16	0.78	16.27	1	090
54312	A	A	RECONSTRUCTION OF URETHRA	13.88	9.86	0.96	24.70	1	090
54316	A	A	RECONSTRUCTION OF URETHRA	16.83	11.95	1.17	29.95	1	090
54318	A	A	RECONSTRUCTION OF URETHRA	11.04	7.93	1.16	20.13	1	090
54322	A	A	RECONSTRUCTION OF URETHRA	11.28	8.01	0.78	20.07	1	090
54324	A	A	RECONSTRUCTION OF URETHRA	16.29	11.57	1.13	28.99	1	090
54326	A	A	RECONSTRUCTION OF URETHRA	15.60	11.08	1.08	27.76	1	090
54328	A	A	REVISE PENIS, URETHRA	15.59	11.29	1.31	28.19	1	090
54332	A	A	REVISE PENIS, URETHRA	17.04	13.20	1.19	31.43	1	090
54336	A	A	REVISE PENIS, URETHRA	16.65	19.80	1.48	37.93	1	090
54340	A	A	SECONDARY URETHRAL SURGERY	9.01	6.40	0.63	16.04	1	090
54344	A	A	SECONDARY URETHRAL SURGERY	16.04	17.50	1.15	34.69	1	090
54348	A	A	SECONDARY URETHRAL SURGERY	17.25	12.24	1.20	30.69	1	090
54352	A	A	RECONSTRUCT URETHRA, PENIS	25.13	17.05	1.57	43.75	1	090
54360	A	A	PENIS PLASTIC SURGERY	9.56	7.40	0.77	17.73	1	090
54380	A	A	REPAIR PENIS	13.27	9.93	0.79	23.99	1	090
54385	A	A	REPAIR PENIS	15.54	11.03	0.94	27.51	1	090
54390	A	A	REPAIR PENIS AND BLADDER	18.86	14.30	1.67	34.83	1	090
54400	A	A	INSERT SEMI-RIGID PROSTHESIS	9.04	13.78	1.34	24.16	1	090
54401	A	A	INSERT SELF-CONTD PROSTHESIS	10.19	18.79	1.82	30.80	1	090
54402	A	A	REMOVE PENIS PROSTHESIS	9.14	6.33	0.62	16.09	1	090
54405	A	A	INSERT MULTI-COMP PROSTHESIS	13.31	22.73	2.21	38.25	1	090
54407	A	A	REMOVE MULTI-COMP PROSTHESIS	13.29	11.82	1.15	26.26	1	090
54409	A	A	REVISE PENIS PROSTHESIS	12.15	9.45	0.92	22.52	1	090
54420	A	A	REVISION OF PENIS	11.33	8.16	0.92	20.41	1	090
54430	A	A	REVISION OF PENIS	10.07	7.37	0.73	18.17	1	090
54435	A	A	REVISION OF PENIS	5.92	4.38	0.41	10.71	1	090
54440	C	A	REPAIR OF PENIS	0.00	0.00	0.00	0.00		090
54450	A	A	PREPUTIAL STRETCHING	1.17	0.72	0.07	1.96	2	000
54500	A	A	BIOPSY OF TESTIS	1.38	0.46	0.05	1.89	2	000
54505	A	A	BIOPSY OF TESTIS	3.60	1.95	0.23	5.78	2	010
54510	A	A	REMOVAL OF TESTIS LESION	5.52	3.19	0.39	9.10	1	090
54520	A	A	REMOVAL OF TESTIS	5.19	5.60	0.56	11.35	1	090
54530	A	A	REMOVAL OF TESTIS	8.48	7.71	0.81	17.00	1	090
54535	A	A	EXTENSIVE TESTIS SURGERY	12.05	8.99	1.07	22.11	1	090
54550	A	A	EXPLORATION FOR TESTIS	7.76	5.53	0.65	13.94	1	090
54560	A	A	EXPLORATION FOR TESTIS	11.03	7.62	0.85	19.50	1	090
54600	A	A	REDUCE TESTIS TORSION	6.94	4.87	0.51	12.32	1	090
54620	A	A	SUSPENSION OF TESTIS	4.94	3.50	0.34	8.78	1	010
54640	A	A	SUSPENSION OF TESTIS	6.90	8.24	0.96	16.10	1	090
54645	A	A	SUSPENSION OF TESTIS, STAGE 2	7.03	2.35	0.74	10.12	1	090
54660	A	A	REVISION OF TESTIS	5.05	3.59	0.35	8.99	1	090
54670	C	A	REPAIR TESTIS INJURY	0.00	0.00	0.00	0.00		090
54680	A	A	RELOCATION OF TESTIS(ES)	12.15	8.63	0.84	21.62	1	090
54700	A	A	DRAINAGE OF SCROTUM	3.57	0.95	0.11	4.63	1	010
54800	A	A	BIOPSY OF EPIDIDYMIS	2.46	2.08	0.20	4.74	2	000
54820	A	A	EXPLORATION OF EPIDIDYMIS	4.97	2.76	0.30	8.03	2	090
54830	A	A	REMOVE EPIDIDYMIS LESION	5.35	3.70	0.41	9.46	1	090
54840	A	A	REMOVE EPIDIDYMIS LESION	5.29	5.09	0.51	10.89	1	090
54860	A	A	REMOVAL OF EPIDIDYMIS	6.34	5.45	0.53	12.32	1	090
54861	A	A	REMOVAL OF EPIDIDYMIS	8.99	7.69	0.76	17.44	1	090
54900	A	A	FUSION OF SPERMATIC DUCTS	13.29	9.43	0.92	23.64	1	090
54901	A	A	FUSION OF SPERMATIC DUCTS	18.23	12.95	1.27	32.45	1	090
55000	A	A	DRAINAGE OF HYDROCELE	1.51	0.42	0.04	1.97	2	000
55040	A	A	REMOVAL OF HYDROCELE	5.43	5.13	0.59	11.15	1	090
55041	A	A	REMOVAL OF HYDROCELES	7.78	7.87	0.85	16.50	1	090
55060	A	A	REPAIR OF HYDROCELE	5.49	4.36	0.53	10.38	1	090
55100	A	A	DRAINAGE OF SCROTUM ABSCESS	2.14	0.67	0.07	2.88	2	010
55110	A	A	EXPLORE SCROTUM	5.56	3.67	0.38	9.61	1	090
55120	A	A	REMOVAL OF SCROTUM LESION	5.03	1.88	0.22	7.13	1	090
55150	A	A	REMOVAL OF SCROTUM	6.97	5.74	0.61	13.32	1	090
55175	A	A	REVISION OF SCROTUM	5.19	4.73	0.51	10.43	1	090
55180	A	A	REVISION OF SCROTUM	10.60	7.20	0.86	18.66	1	090
55200	A	A	INCISION OF SPERM DUCT	4.37	2.08	0.21	6.66	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCCPS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
55250		A	REMOVAL OF SPERM DUCT(S)	3.38	2.78	0.29	6.45	1	090
55300		A	PREPARATION, SPERM DUCT X-RAY	3.70	2.86	0.28	6.84	2	000
55400		A	REPAIR OF SPERM DUCT	8.69	6.91	0.66	16.26	1	090
55450		A	LIGATION OF SPERM DUCT	4.11	2.75	0.33	7.19	1	010
55500		A	REMOVAL OF HYDROCELE	5.56	4.56	0.53	10.65	1	090
55520		A	REMOVAL OF SPERM CORD LESION	6.03	3.28	0.55	9.86	1	090
55530		A	REVISE SPERMATIC CORD VEINS	5.74	5.48	0.64	11.86	1	090
55535		A	REVISE SPERMATIC CORD VEINS	6.58	4.64	0.47	11.69	1	090
55540		A	REVISE HERNIA & SPERM VEINS	7.64	4.78	0.96	13.38	1	090
55600		A	INCISE SPERM DUCT POUCH	6.40	4.55	0.59	11.54	1	090
55605		A	INCISE SPERM DUCT POUCH	8.00	5.89	0.63	14.52	1	090
55650		A	REMOVE SPERM DUCT POUCH	11.87	8.49	0.87	21.23	1	090
55680		A	REMOVE SPERM POUCH LESION	5.07	4.67	0.40	10.14	1	090
55700		A	BIOPSY OF PROSTATE	1.66	1.58	0.15	3.39	2	000
55705		A	BIOPSY OF PROSTATE	4.65	3.55	0.35	8.55	2	010
55720		A	DRAINAGE OF PROSTATE ABSCESS	7.94	3.70	0.38	12.02	1	090
55725		A	DRAINAGE OF PROSTATE ABSCESS	8.12	5.91	0.58	14.61	1	090
55740		A	REMOVAL OF PROSTATE STONE	10.80	15.43	1.50	27.73	1	090
55801		A	REMOVAL OF PROSTATE	17.13	13.44	1.52	32.09	1	090
55810		A	EXTENSIVE PROSTATE SURGERY	22.35	18.84	1.86	43.05	1	090
55812		A	EXTENSIVE PROSTATE SURGERY	24.41	17.34	1.78	43.53	2	090
55815		A	EXTENSIVE PROSTATE SURGERY	26.53	26.56	2.55	55.64	2	090
55821		A	REMOVAL OF PROSTATE	13.69	14.32	1.42	29.43	1	090
55831		A	REMOVAL OF PROSTATE	15.07	15.34	1.52	31.93	1	090
55840		A	EXTENSIVE PROSTATE SURGERY	22.35	17.49	1.70	41.54	2	090
55842		A	EXTENSIVE PROSTATE SURGERY	23.92	20.19	1.99	46.10	2	090
55845		A	EXTENSIVE PROSTATE SURGERY	28.17	26.45	2.57	57.19	2	090
55860		A	SURGICAL EXPOSURE, PROSTATE	14.05	7.51	0.74	22.30	1	090
55862		A	EXTENSIVE PROSTATE SURGERY	18.01	12.32	1.27	31.60	1	090
55865		A	EXTENSIVE PROSTATE SURGERY	22.82	25.84	2.52	51.18	1	090
55870		C	ELECTROEJACULATION	0.00	0.00	0.00	0.00		000
55899		C	GENITAL SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
55970		N	SEX TRANSFORMATION, M TO F	0.00	0.00	0.00	0.00		XXX
55980		N	SEX TRANSFORMATION, F TO M	0.00	0.00	0.00	0.00		XXX
56000		A	DRAINAGE OF PERINEAL ABSCESS	1.53	0.73	0.12	2.38	2	010
56100		A	BIOPSY OF PERINEUM	0.98	0.71	0.14	1.83	2	000
56200		A	REPAIR OF PERINEUM	4.18	2.76	0.55	7.49	1	010
56400		A	DRAINAGE OF VULVA	1.43	0.84	0.16	2.43	2	010
56420		A	DRAINAGE OF GLAND ABSCESS	1.41	0.84	0.13	2.38	2	010
56440		A	SURGERY FOR VULVA LESION	2.94	2.77	0.56	6.27	1	010
56441		A	LYSIS OF LABIAL LESION(S)	2.03	1.45	0.34	3.82	1	010
56501		A	DESTRUCTION, VULVA LESION(S)	1.56	0.58	0.11	2.25	1	010
56515		A	DESTRUCTION, VULVA LESION(S)	1.94	3.24	0.70	5.88	1	010
56600		A	BIOPSY OF VULVA	0.64	0.72	0.15	1.51	2	000
56620		A	PARTIAL REMOVAL OF VULVA	7.67	6.82	1.48	15.97	1	090
56625		A	REMOVAL OF VULVA	8.54	10.66	2.24	21.44	1	090
56630		A	EXTENSIVE VULVA SURGERY	12.07	16.93	3.46	32.46	1	090
56635		A	EXTENSIVE VULVA SURGERY	14.37	22.58	4.75	41.70	1	090
56640		A	EXTENSIVE VULVA SURGERY	18.48	21.02	4.60	44.10	2	090
56680		D	REMOVAL OF CLITORIS	0.00	0.00	0.00	0.00		XXX
56685		D	EXTENSIVE CLITORIS SURGERY	0.00	0.00	0.00	0.00		XXX
56700		A	PARTIAL REMOVAL OF HYMEN	2.55	1.91	0.36	4.82	1	010
56720		A	INCISION OF HYMEN	0.72	0.51	0.11	1.34	2	010
56740		A	REMOVE VAGINA GLAND LESION	3.80	3.02	0.59	7.41	1	010
56800		A	REPAIR OF VAGINA	3.93	3.08	0.61	7.62	1	010
56805		C	REPAIR OF CLITORIS	0.00	0.00	0.00	0.00		090
57000		A	EXPLORATION OF VAGINA	3.08	2.14	0.36	5.58	1	010
57010		A	DRAINAGE OF PELVIC ABSCESS	5.70	2.80	0.55	9.05	1	090
57020		A	DRAINAGE OF PELVIC FLUID	1.58	0.69	0.14	2.41	1	000
57061		A	DESTRUCTION VAGINA LESION(S)	1.27	0.86	0.17	2.30	1	010
57065		A	DESTRUCTION VAGINA LESION(S)	2.69	3.58	0.78	7.05	1	010
57100		A	BIOPSY OF VAGINA	1.02	0.66	0.13	1.81	2	000
57105		A	BIOPSY OF VAGINA	1.73	1.66	0.34	3.73	2	010
57108		A	PARTIAL REMOVAL OF VAGINA	6.00	5.56	1.15	12.71	1	090
57110		A	REMOVAL OF VAGINA	6.85	8.30	1.85	17.00	1	090
57120		A	CLOSURE OF VAGINA	7.09	7.37	1.59	16.05	1	090
57130		A	REMOVE VAGINA LESION	2.53	2.76	0.59	5.88	1	010
57135		A	REMOVE VAGINA LESION	2.79	2.04	0.40	5.23	1	010

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
57150		A	TREAT VAGINA INFECTION	0.99	0.20	0.04	1.23	2	010
57160		A	INSERTION OF PESSARY	0.94	0.26	0.05	1.25	2	010
57170		A	FITTING OF DIAPHRAGM/CAP	0.96	0.72	0.08	1.76	2	000
57180		A	TREAT VAGINAL BLEEDING	1.61	0.59	0.11	2.31	1	010
57200		A	REPAIR OF VAGINA	3.88	2.86	0.64	7.38	1	090
57210		A	REPAIR VAGINA/PERINEUM	4.98	3.45	0.69	9.12	1	090
57220		A	REVISION OF URETHRA	4.07	4.68	0.84	9.59	1	090
57230		A	REPAIR OF URETHRAL LESION	5.35	4.04	0.68	10.07	1	090
57240		A	REPAIR BLADDER & VAGINA	5.68	8.05	1.69	15.42	1	090
57250		A	REPAIR RECTUM & VAGINA	5.24	8.24	1.78	15.26	1	090
57260		A	REPAIR OF VAGINA	7.99	9.12	1.98	19.09	1	090
57265		A	EXTENSIVE REPAIR OF VAGINA	7.76	10.23	2.22	20.21	1	090
57268		A	REPAIR OF BOWEL BULGE	6.47	7.40	1.58	15.45	1	090
57270		A	REPAIR OF BOWEL POUCH	7.76	7.20	1.52	16.48	1	090
57280		A	SUSPENSION OF VAGINA	8.79	8.98	1.94	19.71	1	090
57282		A	REPAIR OF VAGINAL PROLAPSE	8.50	9.20	2.00	19.70	1	090
57288		A	REPAIR BLADDER DEFECT	7.29	11.29	1.44	20.02	1	090
57289		A	REPAIR BLADDER & VAGINA	6.75	9.53	1.19	17.47	1	090
57291		A	CONSTRUCTION OF VAGINA	7.86	5.64	1.26	14.76	1	090
57292		A	CONSTRUCT VAGINA WITH GRAFT	10.10	6.90	1.46	18.46	1	090
57300		A	REPAIR RECTUM-VAGINA FISTULA	7.18	8.34	1.75	17.27	1	090
57305		A	REPAIR RECTUM-VAGINA FISTULA	9.16	7.95	1.65	18.76	1	090
57307		A	FISTULA REPAIR & COLOSTOMY	10.58	6.44	1.35	18.37	1	090
57310		A	REPAIR URETHROVAGINAL LESION	6.43	4.56	0.51	11.50	1	090
57311		A	REPAIR URETHROVAGINAL LESION	7.62	5.87	0.43	13.92	1	090
57320		A	REPAIR BLADDER-VAGINA LESION	7.73	10.28	1.43	19.44	1	090
57330		A	REPAIR BLADDER-VAGINA LESION	12.30	8.73	0.85	21.88	2	090
57335		C	REPAIR OF VAGINA	0.00	0.00	0.00	0.00		090
57400		A	DILATION OF VAGINA	0.87	0.34	0.06	1.27	2	000
57410		A	PELVIC EXAMINATION	0.63	0.37	0.05	1.05	2	000
57450		A	PELVIS ENDOSCOPY VIA VAGINA	4.09	0.98	0.15	5.22	2	010
57451		A	PELVIS ENDOSCOPY & BIOPSY	4.48	1.86	0.38	6.72	2	010
57452		A	EXAMINATION OF VAGINA	1.04	0.69	0.14	1.87	2	000
57454		A	VAGINA EXAMINATION & BIOPSY	1.34	1.28	0.27	2.89	2	000
57500		A	BIOPSY OF CERVIX	1.02	0.61	0.12	1.75	2	000
57505		A	ENDOCERVICAL CURETTAGE	1.14	0.67	0.13	1.94	1	010
57510		A	CAUTERIZATION OF CERVIX	1.94	0.56	0.09	2.59	2	010
57511		A	CRYOCAUTERY OF CERVIX	1.94	0.90	0.17	3.01	2	010
57513		A	LASER SURGERY OF CERVIX	1.94	3.27	0.71	5.92	2	010
57520		A	CONIZATION CERVIX	3.60	3.64	0.77	8.01	1	090
57530		A	REMOVAL OF CERVIX	4.66	3.81	0.82	9.29	1	090
57540		A	REMOVAL OF RESIDUAL CERVIX	6.34	7.10	1.59	15.03	1	090
57545		A	REMOVE CERVIX, REPAIR PELVIS	6.98	4.82	1.08	12.88	1	090
57550		A	REMOVAL OF RESIDUAL CERVIX	5.17	7.77	1.63	14.57	1	090
57555		A	REMOVE CERVIX, REPAIR VAGINA	8.58	10.64	2.28	21.50	1	090
57556		A	REMOVE CERVIX, REPAIR BOWEL	7.96	5.75	1.24	14.95	1	090
57700		A	REVISION OF CERVIX	3.48	2.52	0.35	6.35	1	090
57720		A	REVISION OF CERVIX	4.07	2.91	0.54	7.52	1	090
57800		A	DILATION OF CERVICAL CANAL	0.81	0.51	0.10	1.42	2	000
57820		A	D&C OF RESIDUAL CERVIX	1.71	2.60	0.49	4.80	1	010
58100		A	BIOPSY OF UTERUS LINING	0.75	0.70	0.14	1.59	2	000
58102		A	CURETTAGE OF UTERUS LINING	1.50	0.97	0.20	2.67	1	010
58120		A	DILATION AND CURETTAGE (D&C)	2.58	2.85	0.60	6.03	1	010
58140		A	REMOVAL OF UTERUS LESION	8.01	8.77	1.80	18.58	1	090
58145		A	REMOVAL OF UTERUS LESION	7.76	8.68	1.63	18.07	1	090
58150		A	TOTAL HYSTERECTOMY	13.69	10.09	2.19	25.97	2	090
58152		A	TOTAL HYSTERECTOMY	14.86	12.63	2.73	30.22	2	090
58180		A	PARTIAL HYSTERECTOMY	9.55	10.29	2.22	22.06	2	090
58200		A	EXTENSIVE HYSTERECTOMY	21.44	13.67	2.95	38.06	2	090
58210		A	EXTENSIVE HYSTERECTOMY	25.26	18.73	4.07	48.06	2	090
58240		A	REMOVAL OF PELVIS CONTENTS	30.33	30.27	6.48	67.08	1	090
58260		A	VAGINAL HYSTERECTOMY	12.74	9.90	2.18	24.82	2	090
58267		A	HYSTERECTOMY & VAGINA REPAIR	14.70	12.15	2.59	29.44	2	090
58270		A	HYSTERECTOMY & VAGINA REPAIR	13.28	10.87	2.34	26.49	2	090
58275		A	HYSTERECTOMY, REVISE VAGINA	14.75	11.61	2.45	28.81	2	090
58280		A	HYSTERECTOMY, REVISE VAGINA	15.12	11.07	2.43	28.62	2	090
58285		A	EXTENSIVE HYSTERECTOMY	18.38	12.22	2.85	33.45	2	090
58300		A	INSERT INTRAUTERINE DEVICE	1.06	0.80	0.09	1.95	2	000

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
58301		A	REMOVE INTRAUTERINE DEVICE	0.77	0.59	0.07	1.43	2	000
58310		A	ARTIFICIAL INSEMINATION	0.97	0.75	0.15	1.87	2	000
58311		A	ARTIFICIAL INSEMINATION	0.73	0.52	0.12	1.37	2	000
58340		A	INJECT FOR UTERUS/TUBE X-RAY	0.84	0.61	0.08	1.53	2	222
58350		A	REOPEN FALLOPIAN TUBE	1.01	0.73	0.16	1.90	2	010
58400		A	SUSPENSION OF UTERUS	5.97	5.95	1.22	13.14	1	090
58410		A	SUSPENSION OF UTERUS	7.15	5.82	0.88	13.85	1	090
58520		A	REPAIR OF RUPTURED UTERUS	6.69	4.47	1.04	12.20	1	090
58540		A	REVISION OF UTERUS	9.04	6.46	1.50	17.00	1	090
58600		A	DIVISION OF FALLOPIAN TUBE	3.94	7.35	1.46	12.75	1	090
58605		A	DIVISION OF FALLOPIAN TUBE	3.47	5.28	1.06	9.81	1	090
58611		A	LIGATE OVIDUCT(S)	0.67	0.50	0.10	1.27	2	222
58615		A	OCCCLUDE FALLOPIAN TUBE(S)	4.33	2.52	0.58	7.43	1	010
58700		A	REMOVAL OF FALLOPIAN TUBE	6.24	6.67	1.38	14.29	1	090
58720		A	REMOVAL OF OVARY/TUBE(S)	6.53	7.90	1.72	16.15	1	090
58740		A	REVISE FALLOPIAN TUBE(S)	5.57	9.06	1.97	16.60	1	090
58750		A	REPAIR OVIDUCT(S)	9.30	6.64	1.54	17.48	1	090
58752		A	REVISE OVARIAN TUBE(S)	8.37	7.10	0.98	16.45	1	090
58760		A	REMOVE TUBAL OBSTRUCTION	7.55	5.39	1.25	14.19	1	090
58770		A	CREATE NEW TUBAL OPENING	7.33	5.56	1.16	14.05	1	090
58800		A	DRAINAGE OF OVARIAN CYST(S)	3.97	2.83	0.57	7.37	1	090
58805		A	DRAINAGE OF OVARIAN CYST(S)	5.73	6.72	1.44	13.89	1	090
58820		A	DRAINAGE OF OVARIAN ABSCESS	4.17	2.91	0.52	7.60	1	090
58822		A	DRAINAGE OF OVARIAN ABSCESS	6.51	3.74	0.85	11.10	1	090
58825		A	TRANSPOSITION, OVARY(S)	5.93	4.24	0.98	11.15	1	090
58900		A	BIOPSY OF OVARY(S)	5.78	5.47	1.12	12.37	1	090
58920		A	PARTIAL REMOVAL OF OVARY(S)	6.61	7.15	1.49	15.25	1	090
58925		A	REMOVAL OF OVARIAN CYST(S)	6.75	6.91	1.46	15.12	1	090
58940		A	REMOVAL OF OVARY(S)	6.89	6.84	1.40	15.13	1	090
58943		A	REMOVAL OF OVARY(S)	18.42	12.75	2.77	33.94	2	090
58950		A	RESECT OVARIAN MALIGNANCY	14.86	11.85	2.51	29.22	2	090
58951		A	RESECT OVARIAN MALIGNANCY	21.44	19.32	4.14	44.90	2	090
58952		A	RESECT OVARIAN MALIGNANCY	22.50	19.08	4.12	45.70	2	090
58960		A	EXPLORATION OF ABDOMEN	10.69	14.03	3.11	27.83	1	090
58970		C	RETRIEVAL OF OOCYTE	0.00	0.00	0.00	0.00		000
58972		C	FERTILIZATION OF OOCYTE	0.00	0.00	0.00	0.00		000
58974		C	TRANSFER OF EMBRYO	0.00	0.00	0.00	0.00		000
58976		C	TRANSFER OF EMBRYO	0.00	0.00	0.00	0.00		000
58980		A	LAPAROSCOPY OF PELVIS	4.25	5.01	1.08	10.34	2	010
58982		A	LAPAROSCOPY; TUBAL CAUTERY	3.88	2.95	0.34	7.17	2	010
58983		A	LAPAROSCOPY; TUBAL BLOCK	4.33	3.28	0.38	7.99	2	010
58984		A	LAPAROSCOPY OF PELVIS	4.91	5.82	1.22	11.95	2	010
58985		A	LAPAROSCOPY OF PELVIS	4.61	5.98	1.27	11.86	2	010
58986		A	PELVIS LAPAROSCOPY & BIOPSY	4.51	5.53	1.00	11.04	2	010
58987		A	LAPAROSCOPY OF PELVIS	4.53	5.65	1.24	11.42	2	010
58988		A	LAPAROSCOPY, REMOVE ADNEXA	5.89	4.21	0.97	11.07	2	010
58990		A	DIAGNOSTIC HYSTEROSCOPY	2.52	2.10	0.46	5.08	1	000
58992		A	TREATMENT HYSTEROSCOPY	3.39	2.41	0.51	6.31	1	000
58994		A	TREATMENT HYSTEROSCOPY	4.05	2.97	0.65	7.67	1	000
58996		A	TREATMENT HYSTEROSCOPY	3.62	2.59	0.60	6.81	1	000
58999		C	GENITAL SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
59000		A	AMNIOCENTESIS	1.37	1.02	0.19	2.58	2	000
59012		A	FETAL CORD PUNCTURE, PRENATAL	3.64	2.76	0.32	6.72	2	000
59015		A	CHORION BIOPSY	2.31	1.27	0.10	3.68	2	000
59020		A	FETAL CONTRACT STRESS TEST	0.70	1.26	0.25	2.21	2	000
59020	TC	A	FETAL CONTRACT STRESS TEST	0.00	0.28	0.05	0.33		000
59020	26	A	FETAL CONTRACT STRESS TEST	0.70	0.98	0.20	1.88	2	000
59025		A	FETAL NON-STRESS TEST	0.57	0.64	0.13	1.34	2	000
59025	TC	A	FETAL NON-STRESS TEST	0.00	0.23	0.05	0.28		000
59025	26	A	FETAL NON-STRESS TEST	0.57	0.41	0.08	1.06	2	000
59030		A	FETAL SCALP BLOOD SAMPLE	2.10	1.67	0.22	3.99	2	000
59050		A	FETAL MONITOR W/REPORT	1.63	0.85	0.15	2.63	2	222
59100		A	REMOVE UTERUS LESION	6.29	4.37	1.01	11.67	1	090
59120		A	TREAT ECTOPIC PREGNANCY	7.49	8.28	1.58	17.35	1	090
59121		A	TREAT ECTOPIC PREGNANCY	7.37	5.67	1.12	14.16	1	090
59130		A	TREAT ECTOPIC PREGNANCY	8.30	6.29	0.74	15.33	1	090
59135		A	TREAT ECTOPIC PREGNANCY	9.36	6.69	1.55	17.60	1	090
59136		A	TREAT ECTOPIC PREGNANCY	9.17	6.55	1.52	17.24	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
59140		A	TREAT ECTOPIC PREGNANCY	5.37	4.91	0.30	10.58	1	090
59150		A	TREAT ECTOPIC PREGNANCY	6.68	4.77	1.10	12.55	1	090
59151		A	TREAT ECTOPIC PREGNANCY	7.63	9.07	0.68	17.38	1	090
59160		A	D&C AFTER DELIVERY	2.81	3.09	0.56	6.46	1	010
59200		A	INSERT CERVICAL DILATOR	0.83	0.73	0.11	1.67	1	000
59300		A	EPISIOTOMY OR VAGINAL REPAIR	2.54	1.04	0.10	3.68	2	000
59320		A	REVISION OF CERVIX	2.61	1.87	0.43	4.91	2	000
59325		A	REVISION OF CERVIX	4.29	3.04	0.30	7.63	2	000
59350		A	REPAIR OF UTERUS	5.22	3.73	0.86	9.81	2	000
59400		A	OBSTETRICAL CARE	15.94	8.55	1.61	26.10	2	MMM
59410		A	OBSTETRICAL CARE	6.68	6.28	1.17	14.13	1	MMM
59412		A	ANTEPARTUM MANIPULATION	1.80	1.29	0.30	3.39	2	ZZZ
59414		A	DELIVER PLACENTA	1.70	1.21	0.28	3.19	2	MMM
59420		A	CARE BEFORE DELIVERY	9.27	0.38	0.07	9.72	2	MMM
59430		A	CARE AFTER DELIVERY	2.12	0.39	0.07	2.58	2	MMM
59510		A	CESAREAN DELIVERY	19.32	12.45	2.64	34.41	2	MMM
59515		A	CESAREAN DELIVERY	10.05	10.23	2.02	22.30	1	MMM
59525		A	REMOVE UTERUS AFTER CESAREAN	6.90	4.01	0.93	11.84	2	ZZZ
59812		A	TREATMENT OF MISCARRIAGE	3.26	2.42	0.52	6.20	1	090
59820		A	CARE OF MISCARRIAGE	4.39	3.95	0.81	9.15	1	090
59821		A	TREATMENT OF MISCARRIAGE	4.01	2.87	0.66	7.54	1	090
59830		A	TREAT UTERUS INFECTION	3.74	2.67	0.62	7.03	1	090
59840		A	ABORTION	3.73	3.39	0.73	7.85	1	090
59841		A	ABORTION	3.09	3.95	0.80	7.84	1	090
59850		A	ABORTION	5.75	4.21	0.89	10.85	1	090
59851		A	ABORTION	5.91	4.52	0.93	11.36	1	090
59852		A	ABORTION	8.12	5.80	1.34	15.26	1	090
59870		A	EVACUATE MOLE OF UTERUS	4.30	3.07	0.71	8.08	1	090
59899		C	MATERNITY CARE PROCEDURE	0.00	0.00	0.00	0.00		YYY
60000		A	DRAIN THYROID/TONGUE CYST	1.80	0.64	0.09	2.53	2	010
60100		A	BIOPSY OF THYROID	1.02	1.10	0.12	2.24	2	000
60200		A	REMOVE THYROID LESION	9.31	6.35	1.09	16.75	1	090
60220		A	PARTIAL REMOVAL OF THYROID	10.39	8.99	1.70	21.08	1	090
60225		A	PARTIAL REMOVAL OF THYROID	12.28	11.06	2.03	25.37	1	090
60240		A	REMOVAL OF THYROID	14.87	11.15	2.07	28.09	1	090
60245		A	PARTIAL REMOVAL OF THYROID	12.67	9.53	1.83	24.03	1	090
60246		A	PARTIAL REMOVAL OF THYROID	14.93	12.80	2.38	30.11	1	090
60252		A	REMOVAL OF THYROID	16.23	14.38	2.68	33.29	1	090
60254		A	EXTENSIVE THYROID SURGERY	17.58	20.24	3.24	41.06	1	090
60260		A	REPEAT THYROID SURGERY	15.26	3.30	0.35	18.91	1	090
60270		A	REMOVAL OF THYROID	17.32	14.73	2.67	34.72	1	090
60280		A	REMOVE THYROID DUCT LESION	7.46	8.32	1.16	16.94	1	090
60281		A	REMOVE THYROID DUCT LESION	8.43	5.32	1.00	14.75	1	090
60500		A	EXPLORE PARATHYROID GLANDS	16.23	11.97	2.44	30.64	2	090
60502		A	RE-EXPLORE PARATHYROID GLANDS	20.28	12.00	2.46	34.74	2	090
60505		A	EXPLORE PARATHYROID GLANDS	21.00	13.86	2.70	37.56	1	090
60520		A	REMOVAL OF THYMUS GLAND	18.03	14.27	2.59	34.89	1	090
60540		A	EXPLORE ADRENAL GLAND	16.56	12.69	2.19	31.44	1	090
60545		A	EXPLORE ADRENAL GLAND	19.51	15.04	2.47	37.02	1	090
60600		A	REMOVE CAROTID BODY LESION	16.99	12.08	1.97	31.04	1	090
60605		A	REMOVE CAROTID BODY LESION	19.17	11.28	2.32	32.77	1	090
60699		C	ENDOCRINE SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
61000		A	REMOVE CRANIAL CAVITY FLUID	1.67	1.12	0.18	2.97	2	000
61001		A	REMOVE CRANIAL CAVITY FLUID	1.57	0.93	0.18	2.68	2	000
61020		A	REMOVE BRAIN CAVITY FLUID	1.59	1.33	0.21	3.13	2	000
61026		A	INJECTION INTO BRAIN CANAL	1.78	2.14	0.23	4.15	2	000
61050		A	REMOVE BRAIN CANAL FLUID	1.59	1.30	0.15	3.04	2	000
61055		A	INJECTION INTO BRAIN CANAL	1.70	1.99	0.20	3.89	2	000
61070		A	BRAIN CANAL SHUNT PROCEDURE	0.94	0.52	0.03	1.49	2	000
61105		A	DRILL SKULL FOR EXAMINATION	8.63	7.26	1.31	17.20	2	090
61106		A	DRILL SKULL FOR EXAM/SURGERY	8.78	6.48	1.21	16.47	2	ZZZ
61107		A	DRILL SKULL FOR IMPLANTATION	8.69	7.40	1.33	17.42	2	090
61108		A	DRILL SKULL FOR DRAINAGE	11.38	12.69	2.33	26.40	1	090
61120		A	PIERCE SKULL FOR EXAMINATION	9.80	6.27	1.13	17.20	1	090
61130		A	PIERCE SKULL, EXAM/SURGERY	10.14	5.23	1.01	16.38	1	ZZZ
61140		A	PIERCE SKULL FOR BIOPSY	15.64	14.89	2.69	33.22	1	090
61150		A	PIERCE SKULL FOR DRAINAGE	17.25	15.43	2.78	35.46	1	090
61151		A	PIERCE SKULL FOR DRAINAGE	14.10	2.24	0.38	16.72	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPs*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
61154		A	PIERCE SKULL, REMOVE CLOT	12.84	18.79	3.45	35.08	1	090
61156		A	PIERCE SKULL FOR DRAINAGE	16.05	17.06	3.21	36.32	1	090
61210		A	PIERCE SKULL; IMPLANT DEVICE	8.69	8.83	1.61	19.13	2	090
61215		A	INSERT BRAIN-FLUID DEVICE	10.58	9.48	1.72	21.78	1	090
61250		A	PIERCE SKULL & EXPLORE	11.62	8.47	1.52	21.61	1	090
61253		A	PIERCE SKULL & EXPLORE	13.69	10.14	1.78	25.61	1	090
61304		A	OPEN SKULL FOR EXPLORATION	21.74	27.43	5.03	54.20	1	090
61305		A	OPEN SKULL FOR EXPLORATION	26.11	30.67	5.33	62.11	1	090
61312		A	OPEN SKULL FOR DRAINAGE	21.64	25.43	4.70	51.77	1	090
61313		A	OPEN SKULL FOR DRAINAGE	21.64	25.34	4.62	51.60	2	090
61314		A	OPEN SKULL FOR DRAINAGE	24.00	27.00	4.93	55.93	1	090
61315		A	OPEN SKULL FOR DRAINAGE	27.31	25.73	4.71	57.75	1	090
61320		A	OPEN SKULL FOR DRAINAGE	25.19	19.71	3.60	48.50	1	090
61321		A	OPEN SKULL FOR DRAINAGE	28.10	20.89	3.73	52.72	1	090
61330		A	DECOMPRESS EYE SOCKET	16.49	13.66	1.29	31.44	1	090
61332		A	EXPLORE/BIOPSY EYE SOCKET	27.49	21.84	2.91	52.24	1	090
61333		A	EXPLORE ORBIT; REMOVE LESION	28.19	21.56	3.44	53.19	1	090
61334		A	EXPLORE ORBIT; REMOVE OBJECT	17.99	15.43	1.91	35.33	1	090
61340		A	RELIEVE CRANIAL PRESSURE	12.18	16.39	2.67	31.24	1	090
61343		A	INCISE SKULL, PRESSURE RELIEF	29.37	31.66	5.57	66.60	1	090
61345		A	RELIEVE CRANIAL PRESSURE	26.72	20.21	3.64	50.57	1	090
61440		A	INCISE SKULL FOR SURGERY	26.13	21.87	3.16	51.16	1	090
61450		A	INCISE SKULL FOR SURGERY	25.59	21.53	3.62	50.74	1	090
61458		A	INCISE SKULL FOR BRAIN WOUND	27.37	28.74	5.12	61.23	1	090
61460		A	INCISE SKULL FOR SURGERY	28.19	26.39	4.19	58.77	1	090
61470		A	INCISE SKULL FOR SURGERY	21.91	14.60	2.66	39.17	1	090
61480		A	INCISE SKULL FOR SURGERY	17.67	15.88	1.87	35.42	1	090
61490		A	INCISE SKULL FOR SURGERY	16.47	12.35	2.27	31.09	1	090
61500		A	REMOVAL OF SKULL LESION	17.85	21.15	3.78	42.78	1	090
61501		A	REMOVE INFECTED SKULL BONE	18.94	14.71	2.40	36.05	1	090
61510		A	REMOVAL OF BRAIN LESION	24.65	28.49	5.16	58.30	1	090
61512		A	REMOVE BRAIN LINING LESION	25.56	30.58	5.57	61.71	1	090
61514		A	REMOVAL OF BRAIN ABSCESS	24.75	26.89	4.99	56.63	1	090
61516		A	REMOVAL OF BRAIN LESION	24.06	27.90	4.81	56.77	1	090
61518		A	REMOVAL OF BRAIN LESION	34.01	31.63	5.75	71.39	1	090
61519		A	REMOVE BRAIN LINING LESION	35.66	32.91	6.08	74.65	1	090
61520		A	REMOVAL OF BRAIN LESION	40.41	35.67	6.21	82.29	1	090
61521		A	REMOVAL OF BRAIN LESION	41.61	34.75	6.17	82.53	1	090
61522		A	REMOVAL OF BRAIN ABSCESS	29.04	21.04	3.99	54.07	1	090
61524		A	REMOVAL OF BRAIN LESION	27.42	28.94	5.43	61.79	1	090
61526		A	REMOVAL OF BRAIN LESION	31.31	35.84	5.04	72.19	1	090
61530		C	REMOVAL OF BRAIN LESION	0.00	0.00	0.00	0.00		090
61533		A	INSERT BRAIN ELECTRODES	20.82	15.51	2.83	39.16	1	090
61534		A	REMOVAL OF BRAIN LESION	20.15	6.72	2.12	28.99	1	090
61535		A	REMOVE BRAIN ELECTRODES	10.78	8.07	1.32	20.17	1	090
61536		A	REMOVAL OF BRAIN LESION	31.01	23.13	4.20	58.34	1	090
61538		A	REMOVAL OF BRAIN TISSUE	29.55	30.64	5.25	65.44	1	090
61539		A	REMOVAL OF BRAIN TISSUE	31.66	24.20	4.29	60.15	1	090
61541		A	INCISION OF BRAIN TISSUE	28.40	20.86	3.98	53.24	1	090
61542		A	REMOVAL OF BRAIN TISSUE	28.85	20.98	4.10	53.93	1	090
61543		A	REMOVAL OF BRAIN TISSUE	21.72	18.17	2.62	42.51	1	090
61544		A	REMOVE & TREAT BRAIN LESION	24.99	29.71	2.22	56.92	1	090
61545		A	EXCISION OF BRAIN TUMOR	36.35	27.04	5.05	68.44	1	090
61546		A	REMOVAL OF PITUITARY GLAND	30.91	28.46	5.03	64.40	1	090
61548		A	REMOVAL OF PITUITARY GLAND	21.23	26.12	4.24	51.59	1	090
61550		A	RELEASE OF SKULL SEAMS	15.01	12.45	1.16	28.62	1	090
61552		A	RELEASE OF SKULL SEAMS	20.04	14.57	2.85	37.46	1	090
61556		C	INCISE SKULL/SUTURES	0.00	0.00	0.00	0.00		090
61557		C	INCISE SKULL/SUTURES	0.00	0.00	0.00	0.00		090
61558		C	EXCISION OF SKULL/SUTURES	0.00	0.00	0.00	0.00		090
61559		C	EXCISION OF SKULL/SUTURES	0.00	0.00	0.00	0.00		090
61563		C	EXCISION OF SKULL TUMOR	0.00	0.00	0.00	0.00		090
61564		C	EXCISION OF SKULL TUMOR	0.00	0.00	0.00	0.00		090
61570		A	REMOVE BRAIN FOREIGN BODY	24.11	17.37	3.22	44.70	1	090
61571		A	INCISE SKULL FOR BRAIN WOUND	25.87	19.30	3.38	48.55	1	090
61575		A	SKULL BASE/BRAINSTEM SURGERY	34.07	34.77	5.33	74.17	1	090
61576		A	SKULL BASE/BRAINSTEM SURGERY	35.64	29.75	4.11	69.50	1	090
61624		A	OCCCLUSION/EMBOLIZATION CATH	21.23	16.10	1.88	39.21	2	ZZZ

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
61626		A	OCCCLUSION/EMBOLIZATION CATH	17.51	13.28	1.55	32.34	2	ZZZ
61680		C	INTRACRANIAL VESSEL SURGERY	0.00	0.00	0.00	0.00		090
61682		C	INTRACRANIAL VESSEL SURGERY	0.00	0.00	0.00	0.00		090
61684		C	INTRACRANIAL VESSEL SURGERY	0.00	0.00	0.00	0.00		090
61686		C	INTRACRANIAL VESSEL SURGERY	0.00	0.00	0.00	0.00		090
61690		A	INTRACRANIAL VESSEL SURGERY	35.64	28.95	4.31	68.90	1	090
61692		C	INTRACRANIAL VESSEL SURGERY	0.00	0.00	0.00	0.00		090
61700		A	INNER SKULL VESSEL SURGERY	36.70	33.39	5.98	76.07	1	090
61702		C	INNER SKULL VESSEL SURGERY	0.00	0.00	0.00	0.00		090
61703		A	CLAMP NECK ARTERY	17.15	12.87	2.36	32.38	1	090
61705		A	REVISE CIRCULATION TO HEAD	36.34	32.04	5.53	73.91	1	090
61708		A	REVISE CIRCULATION TO HEAD	35.40	26.56	2.45	64.41	1	090
61710		A	REVISE CIRCULATION TO HEAD	29.64	17.53	1.84	49.01	1	090
61711		A	FUSION OF SKULL ARTERIES	36.49	34.82	6.53	77.84	1	090
61712		A	SKULL OR SPINE MICROSURGERY	3.68	5.61	0.98	10.27	2	ZZZ
61720		A	INCISE SKULL/BRAIN SURGERY	10.93	26.21	4.26	41.40	1	090
61735		A	INCISE SKULL/BRAIN SURGERY	12.32	8.96	1.75	23.03	1	090
61750		A	INCISE SKULL; BRAIN BIOPSY	10.56	25.34	4.55	40.45	1	090
61751		A	BRAIN BIOPSY WITH CAT SCAN	10.91	26.69	4.68	42.28	1	090
61770		A	INCISE SKULL FOR TREATMENT	15.95	20.67	3.62	40.24	1	090
61780		A	INCISE SKULL/BRAIN EXAM	8.80	6.40	1.14	16.34	1	090
61790		A	TREAT TRIGEMINAL NERVE	10.86	18.14	3.19	32.19	1	090
61791		A	TREAT TRIGEMINAL TRACT	7.68	18.18	3.33	29.19	1	090
61793		A	FOCUS RADIATION BEAM	17.60	22.50	2.07	42.17	1	090
61795		A	BRAIN SURGERY USING COMPUTER	4.25	3.09	0.60	7.94	2	ZZZ
61850		A	IMPLANT NEUROELECTRODES	16.84	12.25	2.39	31.48	1	090
61855		A	IMPLANT NEUROELECTRODES	13.63	10.95	1.55	26.13	1	090
61860		A	IMPLANT NEUROELECTRODES	11.80	8.58	1.68	22.06	1	090
61865		A	IMPLANT NEUROELECTRODES	22.87	16.63	3.25	42.75	1	090
61870		A	IMPLANT NEUROELECTRODES	6.08	4.42	0.86	11.36	1	090
61875		A	IMPLANT NEUROELECTRODES	9.69	7.05	1.38	18.12	2	090
61880		A	REVISE/REMOVE NEUROELECTRODE	6.03	5.04	0.70	11.77	1	090
61885		A	IMPLANT NEURORECEIVER	2.48	2.07	0.30	4.85	1	090
61888		A	REVISE/REMOVE NEURORECEIVER	3.26	2.37	0.46	6.09	1	010
62000		A	REPAIR OF SKULL FRACTURE	11.87	6.04	1.00	18.91	1	090
62005		A	REPAIR OF SKULL FRACTURE	15.63	11.68	2.08	29.39	1	090
62010		A	TREATMENT OF HEAD INJURY	19.42	20.23	3.58	43.23	1	090
62100		A	REPAIR BRAIN FLUID LEAKAGE	21.90	22.78	3.92	48.60	1	090
62115		C	REDUCTION OF SKULL DEFECT	0.00	0.00	0.00	0.00		090
62116		C	REDUCTION OF SKULL DEFECT	0.00	0.00	0.00	0.00		090
62117		C	REDUCTION OF SKULL DEFECT	0.00	0.00	0.00	0.00		090
62120		C	REPAIR SKULL CAVITY LESION	0.00	0.00	0.00	0.00		090
62121		A	INCISE SKULL REPAIR	25.37	18.44	3.60	47.41	2	090
62140		A	REPAIR OF SKULL DEFECT	13.31	14.15	2.52	29.98	1	090
62141		A	REPAIR OF SKULL DEFECT	14.65	18.69	3.46	36.80	2	090
62142		A	REMOVE SKULL PLATE/FLAP	10.44	14.81	2.79	28.04	1	090
62143		A	REPLACE SKULL PLATE/FLAP	12.76	9.66	1.74	24.16	1	090
62145		A	REPAIR OF SKULL & BRAIN	18.64	13.88	2.42	34.94	1	090
62146		A	REPAIR OF SKULL WITH GRAFT	15.92	11.58	2.26	29.76	2	090
62147		A	REPAIR OF SKULL WITH GRAFT	19.11	13.89	2.71	35.71	2	090
62180		A	ESTABLISH BRAIN CAVITY SHUNT	12.72	14.98	2.85	30.55	1	090
62190		A	ESTABLISH BRAIN CAVITY SHUNT	10.67	17.27	3.38	31.32	1	090
62192		A	ESTABLISH BRAIN CAVITY SHUNT	11.92	15.53	2.89	30.34	1	090
62194		A	REPLACE/IRRIGATE CATHETER	2.96	1.98	0.30	5.24	1	010
62200		A	ESTABLISH BRAIN CAVITY SHUNT	13.96	10.33	1.95	26.24	1	090
62201		A	ESTABLISH BRAIN CAVITY SHUNT	12.74	9.26	1.81	23.81	2	090
62220		A	ESTABLISH BRAIN CAVITY SHUNT	12.70	18.05	3.28	34.03	1	090
62223		A	ESTABLISH BRAIN CAVITY SHUNT	13.02	17.49	3.18	33.69	1	090
62225		A	REPLACE/IRRIGATE CATHETER	4.96	5.05	0.62	10.63	1	090
62230		A	REPLACE/REVISE BRAIN SHUNT	10.23	10.36	1.91	22.50	1	090
62256		A	REMOVE BRAIN CAVITY SHUNT	6.22	6.73	1.23	14.18	1	090
62258		A	REPLACE BRAIN CAVITY SHUNT	14.33	15.57	2.68	32.58	1	090
62268		A	DRAIN SPINAL CORD CYST	4.07	3.14	0.37	7.58	2	000
62269		A	NEEDLE BIOPSY SPINAL CORD	4.29	1.84	0.29	6.42	2	000
62270		A	SPINAL FLUID TAP, DIAGNOSTIC	1.18	0.75	0.06	1.99	2	000
62272		A	DRAIN SPINAL FLUID	1.43	1.06	0.12	2.61	2	000
62273		A	TREAT LUMBAR SPINE LESION	2.26	1.17	0.27	3.70	2	000
62274		A	INJECT SPINAL ANESTHETIC	1.61	0.78	0.18	2.57	2	ZZZ

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
62275		A	INJECT SPINAL ANESTHETIC	1.88	0.63	0.20	2.71	2	ZZZ
62276		A	INJECT SPINAL ANESTHETIC	2.15	1.30	0.24	3.69	2	ZZZ
62277		A	INJECT SPINAL ANESTHETIC	2.07	0.88	0.24	3.19	2	ZZZ
62278		A	INJECT SPINAL ANESTHETIC	1.59	1.03	0.27	2.89	2	ZZZ
62279		A	INJECT SPINAL ANESTHETIC	1.67	0.86	0.25	2.78	2	ZZZ
62280		A	TREAT SPINAL CORD LESION	2.72	0.75	0.14	3.61	2	010
62281		A	TREAT SPINAL CORD LESION	2.75	0.92	0.29	3.96	2	010
62282		A	TREAT SPINAL CANAL LESION	2.41	1.79	0.42	4.62	2	010
62284		A	INJECTION FOR MYELOGRAM	1.63	2.36	0.35	4.34	2	ZZZ
62287		A	PERCUTANEOUS DISCECTOMY	9.29	7.04	0.82	17.15	2	090
62288		A	INJECTION INTO SPINAL CANAL	1.83	1.17	0.25	3.25	2	000
62289		A	INJECTION INTO SPINAL CANAL	1.73	1.12	0.30	3.15	2	000
62290		A	INJECT FOR SPINE DISK X-RAY	3.77	1.95	0.25	5.97	2	ZZZ
62291		A	INJECT FOR SPINE DISK X-RAY	3.07	1.87	0.41	5.35	2	ZZZ
62292		A	INJECTION INTO DISK LESION	7.38	13.50	2.24	23.12	1	090
62294		A	INJECTION INTO SPINAL ARTERY	8.49	6.15	0.72	15.36	2	090
62298		A	INJECTION INTO SPINAL CANAL	1.44	1.09	0.13	2.66	2	000
63001		A	REMOVAL OF SPINAL LAMINA	15.27	20.19	3.61	39.07	1	090
63003		A	REMOVAL OF SPINAL LAMINA	15.41	18.90	3.40	37.71	1	090
63005		A	REMOVAL OF SPINAL LAMINA	15.62	18.84	3.26	37.72	1	090
63011		A	REMOVAL OF SPINAL LAMINA	13.63	10.52	1.96	26.11	1	090
63012		A	REMOVAL OF SPINAL LAMINA	14.98	10.89	2.13	28.00	1	090
63015		A	REMOVAL OF SPINAL LAMINA	17.48	24.43	4.41	46.32	1	090
63016		A	REMOVAL OF SPINAL LAMINA	18.36	23.56	4.33	46.25	1	090
63017		A	REMOVAL OF SPINAL LAMINA	17.51	24.09	4.21	45.81	1	090
63020		A	NECK SPINE DISK SURGERY	13.21	19.50	3.56	36.27	1	090
63030		A	LOW BACK DISK SURGERY	11.46	16.75	2.96	31.17	1	090
63035		A	ADDED SPINAL DISK SURGERY	3.32	4.48	0.80	8.60	1	ZZZ
63040		A	NECK SPINE DISK SURGERY	16.99	25.00	4.54	46.53	1	090
63042		A	LOW BACK DISK SURGERY	16.67	25.85	4.62	47.14	1	090
63045		A	REMOVAL OF SPINAL LAMINA	16.13	25.48	4.62	46.23	1	090
63046		A	REMOVAL OF SPINAL LAMINA	15.39	26.25	4.82	46.46	1	090
63047		A	REMOVAL OF SPINAL LAMINA	13.44	27.25	4.72	45.41	1	090
63048		A	REMOVAL OF SPINAL LAMINA	3.44	6.12	1.08	10.64	1	ZZZ
63055		A	DECOMPRESS SPINAL CORD	21.79	25.01	4.41	51.21	1	090
63056		A	DECOMPRESS SPINAL CORD	20.13	23.01	3.96	47.10	1	090
63057		A	DECOMPRESS SPINAL CORD	3.16	2.59	0.44	6.19	1	ZZZ
63064		A	DECOMPRESS SPINAL CORD	21.76	25.12	4.31	51.19	1	090
63066		A	DECOMPRESS SPINAL CORD	3.44	2.61	0.48	6.53	1	ZZZ
63075		A	NECK SPINE DISK SURGERY	14.42	18.52	3.38	36.32	1	090
63076		A	NECK SPINE DISK SURGERY	4.27	5.77	1.02	11.06	1	ZZZ
63077		A	SPINE DISK SURGERY, THORAX	21.34	17.59	3.04	41.97	1	090
63078		A	SPINE DISK SURGERY, THORAX	3.46	2.75	0.48	6.69	1	ZZZ
63081		A	REMOVAL OF VERTEBRAL BODY	21.94	27.67	4.74	54.35	1	090
63082		A	REMOVAL OF VERTEBRAL BODY	4.61	7.60	1.29	13.50	1	ZZZ
63085		A	REMOVAL OF VERTEBRAL BODY	26.42	28.85	4.94	60.21	1	090
63086		A	REMOVAL OF VERTEBRAL BODY	3.36	6.32	1.12	10.80	1	ZZZ
63087		A	REMOVAL OF VERTEBRAL BODY	27.44	29.77	5.10	62.31	1	090
63088		A	REMOVAL OF VERTEBRAL BODY	4.57	7.37	1.24	13.18	1	ZZZ
63090		A	REMOVAL OF VERTEBRAL BODY	26.44	30.79	5.18	62.41	1	090
63091		A	REMOVAL OF VERTEBRAL BODY	3.19	2.88	0.49	6.56	1	ZZZ
63170		A	INCISE SPINAL CORD TRACT(S)	19.15	19.89	3.46	42.50	1	090
63172		A	DRAINAGE OF SPINAL CYST	17.07	26.06	4.49	47.62	1	090
63173		A	DRAINAGE OF SPINAL CYST	19.65	14.64	2.66	36.95	1	090
63180		A	REVISE SPINAL CORD LIGAMENTS	17.65	12.23	2.16	32.04	1	090
63182		A	REVISE SPINAL CORD LIGAMENTS	19.92	17.32	2.32	39.56	1	090
63185		A	INCISE SPINAL COLUMN/NERVES	14.59	16.39	3.09	34.07	1	090
63190		A	INCISE SPINAL COLUMN/NERVES	17.14	22.29	4.11	43.54	1	090
63191		A	INCISE SPINAL COLUMN/NERVES	17.30	13.74	2.32	33.36	1	090
63194		A	INCISE SPINAL COLUMN & CORD	18.46	13.71	2.46	34.63	1	090
63195		A	INCISE SPINAL COLUMN & CORD	18.08	14.60	2.22	34.90	1	090
63196		A	INCISE SPINAL COLUMN & CORD	20.95	14.44	2.90	38.29	1	090
63197		A	INCISE SPINAL COLUMN & CORD	20.43	15.13	2.76	38.32	1	090
63198		A	INCISE SPINAL COLUMN & CORD	23.66	17.20	3.36	44.22	1	090
63199		A	INCISE SPINAL COLUMN & CORD	25.18	22.55	2.75	50.48	1	090
63200		A	RELEASE OF SPINAL CORD	18.62	13.17	1.92	33.71	1	090
63250		A	REVISE SPINAL CORD VESSELS	40.74	29.49	5.50	75.73	1	090
63251		A	REVISE SPINAL CORD VESSELS	40.95	23.96	4.56	69.47	1	090

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ADDENDUM B
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HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
63252		A	REVISE SPINAL CORD VESSELS	40.94	29.77	5.81	76.52	1	090
63265		A	EXCISE INTRASPINAL LESION	21.12	23.19	4.10	48.41	1	090
63266		A	EXCISE INTRASPINAL LESION	21.76	26.10	4.67	52.53	1	090
63267		A	EXCISE INTRASPINAL LESION	17.60	24.71	4.43	46.74	1	090
63268		A	EXCISE INTRASPINAL LESION	18.20	13.24	2.59	34.03	1	090
63270		A	EXCISE INTRASPINAL LESION	26.18	19.11	3.61	48.90	1	090
63271		A	EXCISE INTRASPINAL LESION	26.30	28.03	5.04	59.37	1	090
63272		A	EXCISE INTRASPINAL LESION	24.96	24.40	4.50	53.86	1	090
63273		A	EXCISE INTRASPINAL LESION	23.87	18.50	3.28	45.65	1	090
63275		A	BIOPSY/EXCISE SPINAL TUMOR	23.24	29.32	5.37	57.93	1	090
63276		A	BIOPSY/EXCISE SPINAL TUMOR	22.93	26.67	4.87	54.47	1	090
63277		A	BIOPSY/EXCISE SPINAL TUMOR	20.56	25.03	4.48	50.07	1	090
63278		A	BIOPSY/EXCISE SPINAL TUMOR	20.27	24.59	4.56	49.42	1	090
63280		A	BIOPSY/EXCISE SPINAL TUMOR	28.16	29.58	5.27	63.01	1	090
63281		A	BIOPSY/EXCISE SPINAL TUMOR	27.83	29.16	5.24	62.23	1	090
63282		A	BIOPSY/EXCISE SPINAL TUMOR	26.30	25.41	4.68	56.39	1	090
63283		A	BIOPSY/EXCISE SPINAL TUMOR	24.83	19.78	3.63	48.24	1	090
63285		A	BIOPSY/EXCISE SPINAL TUMOR	36.08	25.81	4.73	66.62	1	090
63286		A	BIOPSY/EXCISE SPINAL TUMOR	35.77	30.30	5.18	71.25	1	090
63287		A	BIOPSY/EXCISE SPINAL TUMOR	36.28	27.10	4.77	68.15	1	090
63290		A	BIOPSY/EXCISE SPINAL TUMOR	36.93	28.62	4.90	70.45	1	090
63300		A	REMOVAL OF VERTEBRAL BODY	20.88	15.97	2.71	39.56	1	090
63301		A	REMOVAL OF VERTEBRAL BODY	26.43	19.45	3.77	49.65	1	090
63302		A	REMOVAL OF VERTEBRAL BODY	26.97	22.51	3.18	52.66	1	090
63303		A	REMOVAL OF VERTEBRAL BODY	25.51	19.50	3.58	48.59	1	090
63304		A	REMOVAL OF VERTEBRAL BODY	26.16	19.02	3.72	48.90	1	090
63305		A	REMOVAL OF VERTEBRAL BODY	28.39	23.70	3.95	56.04	1	090
63306		A	REMOVAL OF VERTEBRAL BODY	29.22	27.86	4.56	61.64	1	090
63307		A	REMOVAL OF VERTEBRAL BODY	28.74	25.74	3.14	57.62	1	090
63308		A	REMOVAL OF VERTEBRAL BODY	5.53	4.27	0.77	10.57	1	222
63600		A	REMOVE SPINAL CORD LESION	13.78	11.27	2.78	27.83	1	090
63610		A	STIMULATION OF SPINAL CORD	9.21	7.09	2.17	18.47	2	000
63615		A	REMOVE LESION OF SPINAL CORD	16.23	12.17	2.14	30.54	1	090
63650		A	IMPLANT NEUROELECTRODES	6.32	10.67	2.24	19.23	1	090
63655		A	IMPLANT NEUROELECTRODES	9.43	21.98	3.84	35.25	1	090
63657		A	IMPLANT NEUROELECTRODES	9.68	6.87	0.67	17.22	1	090
63658		A	IMPLANT NEUROELECTRODES	10.68	16.95	3.24	30.87	1	090
63660		A	REVISE/REMOVE NEUROELECTRODE	5.83	8.30	1.65	15.78	1	090
63685		A	IMPLANT NEURORECEIVER	6.62	7.80	1.54	15.96	1	090
63688		A	REVISE/REMOVE NEURORECEIVER	5.02	7.14	1.33	13.49	1	090
63690		A	ANALYSIS OF NEURORECEIVER	0.48	0.35	0.07	0.90	2	090
63691		A	ANALYSIS OF NEURORECEIVER	0.69	0.50	0.10	1.29	2	090
63700		C	REPAIR OF SPINAL HERNIATION	0.00	0.00	0.00	0.00		090
63702		C	REPAIR OF SPINAL HERNIATION	0.00	0.00	0.00	0.00		090
63704		C	REPAIR OF SPINAL HERNIATION	0.00	0.00	0.00	0.00		090
63706		C	REPAIR OF SPINAL HERNIATION	0.00	0.00	0.00	0.00		090
63707		A	REPAIR SPINAL FLUID LEAKAGE	10.68	15.66	2.69	29.03	1	090
63709		A	REPAIR SPINAL FLUID LEAKAGE	13.98	19.20	3.48	36.66	1	090
63710		A	GRAFT REPAIR OF SPINE DEFECT	13.70	10.28	1.67	25.65	1	090
63740		A	INSTALL SPINAL SHUNT	10.06	17.07	3.15	30.28	1	090
63741		A	INSTALL SPINAL SHUNT	7.51	5.46	1.07	14.04	1	090
63744		A	REVISION OF SPINAL SHUNT	7.20	8.59	1.77	17.56	1	090
63746		A	REMOVAL OF SPINAL SHUNT	5.89	3.74	0.76	10.39	1	090
63750		A	INSERT SPINAL CANAL CATHETER	7.62	16.07	3.19	26.88	1	090
63780		A	INSERT SPINAL CANAL CATHETER	6.55	2.04	0.59	9.18	1	090
64400		A	INJECTION FOR NERVE BLOCK	1.40	0.51	0.05	1.96	2	010
64402		A	INJECTION FOR NERVE BLOCK	1.51	0.66	0.09	2.26	2	010
64405		A	INJECTION FOR NERVE BLOCK	1.52	0.68	0.07	2.27	2	010
64408		A	INJECTION FOR NERVE BLOCK	1.84	1.09	0.11	3.04	2	010
64410		A	INJECTION FOR NERVE BLOCK	1.86	1.35	0.18	3.39	2	010
64412		A	INJECTION FOR NERVE BLOCK	1.43	0.66	0.08	2.17	2	010
64413		A	INJECTION FOR NERVE BLOCK	1.73	0.78	0.08	2.59	2	010
64415		A	INJECTION FOR NERVE BLOCK	1.78	0.27	0.07	2.12	2	010
64417		A	INJECTION FOR NERVE BLOCK	1.76	0.67	0.15	2.58	2	010
64418		A	INJECTION FOR NERVE BLOCK	1.59	0.89	0.10	2.58	2	010
64420		A	INJECTION FOR NERVE BLOCK	1.54	0.68	0.07	2.29	2	010
64421		A	INJECTION FOR NERVE BLOCK	2.18	0.87	0.17	3.22	2	010
64425		A	INJECTION FOR NERVE BLOCK	1.84	0.61	0.10	2.55	2	010

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HCPs*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
64430		A	INJECTION FOR NERVE BLOCK	1.89	0.74	0.12	2.75	2	010
64435		A	INJECTION FOR NERVE BLOCK	1.89	0.50	0.09	2.48	2	010
64440		A	INJECTION FOR NERVE BLOCK	1.77	0.83	0.09	2.69	2	010
64441		A	INJECTION FOR NERVE BLOCK	2.25	1.06	0.12	3.43	2	010
64442		A	INJECTION FOR NERVE BLOCK	1.88	1.25	0.16	3.29	2	010
64443		A	INJECTION FOR NERVE BLOCK	1.72	0.67	0.12	2.51	2	010
64445		A	INJECTION FOR NERVE BLOCK	1.92	0.52	0.06	2.50	2	010
64450		A	INJECTION FOR NERVE BLOCK	1.69	0.57	0.05	2.31	2	010
64505		A	INJECTION FOR NERVE BLOCK	1.75	0.66	0.06	2.47	2	010
64508		A	INJECTION FOR NERVE BLOCK	1.49	1.09	0.08	2.66	2	010
64510		A	INJECTION FOR NERVE BLOCK	1.71	0.75	0.19	2.65	2	010
64520		A	INJECTION FOR NERVE BLOCK	1.74	0.76	0.17	2.67	2	010
64530		A	INJECTION FOR NERVE BLOCK	2.08	1.23	0.29	3.60	2	010
64550		A	APPLY NEUROSTIMULATOR	0.19	0.46	0.04	0.69	2	ZZZ
64553		A	IMPLANT NEUROELECTRODES	2.39	1.07	0.10	3.56	2	010
64555		A	IMPLANT NEUROELECTRODES	2.34	0.44	0.10	2.88	2	010
64560		A	IMPLANT NEUROELECTRODES	2.44	1.53	0.25	4.22	2	010
64565		A	IMPLANT NEUROELECTRODES	1.80	0.80	0.08	2.68	2	010
64573		A	IMPLANT NEUROELECTRODES	4.59	3.33	0.65	8.57	2	090
64575		A	IMPLANT NEUROELECTRODES	4.51	3.23	0.42	8.16	2	090
64577		A	IMPLANT NEUROELECTRODES	4.78	2.91	0.48	8.17	2	090
64580		A	IMPLANT NEUROELECTRODES	4.25	3.07	0.21	7.53	2	090
64585		A	REVISE/REMOVE NEUROELECTRODE	2.12	1.02	0.09	3.23	2	010
64590		A	IMPLANT NEURORECEIVER	2.48	1.93	0.36	4.77	2	010
64595		A	REVISE/REMOVE NEURORECEIVER	1.77	1.17	0.22	3.16	2	010
64600		A	INJECTION TREATMENT OF NERVE	3.59	1.78	0.18	5.55	1	090
64605		A	INJECTION TREATMENT OF NERVE	5.85	3.57	0.70	10.12	1	090
64610		A	INJECTION TREATMENT OF NERVE	8.05	7.65	1.43	17.13	1	090
64612		A	DESTROY NERVE, FACE MUSCLE	2.02	1.53	0.18	3.73	2	010
64613		A	DESTROY NERVE, SPINE MUSCLE	2.02	1.53	0.18	3.73	2	010
64620		A	INJECTION TREATMENT OF NERVE	3.33	1.05	0.20	4.58	1	090
64622		A	INJECTION TREATMENT OF NERVE	3.64	1.91	0.36	5.91	1	090
64623		A	INJECTION TREATMENT OF NERVE	1.04	0.90	0.18	2.12	1	ZZZ
64630		A	INJECTION TREATMENT OF NERVE	3.45	1.83	0.39	5.67	1	090
64640		A	INJECTION TREATMENT OF NERVE	3.44	0.97	0.09	4.50	1	090
64680		A	INJECTION TREATMENT OF NERVE	3.18	1.64	0.43	5.25	2	090
64702		A	REVISE FINGER/TOE NERVE	4.23	4.45	0.74	9.42	1	090
64704		A	REVISE HAND/FOOT NERVE	4.68	5.67	0.78	11.13	1	090
64708		A	REVISE ARM/LEG NERVE	6.02	7.83	1.33	15.18	1	090
64712		A	REVISION OF SCIATIC NERVE	7.57	9.85	1.77	19.19	1	090
64713		A	REVISION OF ARM NERVE(S)	10.89	9.91	1.81	22.61	1	090
64714		A	REVISION OF LOW BACK NERVE(S)	10.40	6.46	1.49	18.35	1	090
64716		A	REVISION OF CRANIAL NERVE	6.11	5.08	0.71	11.90	1	090
64718		A	REVISE ULNAR NERVE AT ELBOW	5.77	7.08	1.19	14.04	1	090
64719		A	REVISE ULNAR NERVE AT WRIST	4.97	5.22	0.89	11.08	1	090
64721		A	CARPAL TUNNEL SURGERY	4.20	5.16	0.87	10.23	1	090
64722		A	RELIEVE PRESSURE ON NERVE(S)	4.70	7.06	1.16	12.92	1	090
64726		A	RELEASE FOOT/TOE NERVE	4.18	0.76	0.07	5.01	1	090
64727		A	INTERNAL NERVE REVISION	3.26	3.42	0.59	7.27	2	ZZZ
64732		A	INCISION OF BROW NERVE	4.38	4.55	0.76	9.69	1	090
64734		A	INCISION OF CHEEK NERVE	4.87	4.85	0.71	10.43	1	090
64736		A	INCISION OF CHIN NERVE	4.64	5.25	0.51	10.40	1	090
64738		A	INCISION OF JAW NERVE	5.71	5.35	0.65	11.71	1	090
64740		A	INCISION OF TONGUE NERVE	5.57	5.46	0.66	11.69	1	090
64742		A	INCISION OF FACIAL NERVE	6.23	5.28	0.46	11.97	1	090
64744		A	INCISE NERVE, BACK OF HEAD	5.12	6.43	1.15	12.70	1	090
64746		A	INCISE DIAPHRAGM NERVE	5.91	3.97	0.81	10.69	1	090
64752		A	INCISION OF VAGUS NERVE	6.99	4.14	0.90	12.03	1	090
64755		A	INCISION OF STOMACH NERVES	13.80	11.04	2.40	27.24	2	090
64760		A	INCISION OF VAGUS NERVE	6.89	7.01	1.58	15.48	1	090
64761		A	INCISION OF PELVIS NERVE	6.43	4.91	0.54	11.88	1	090
64763		A	INCISE HIP/THIGH NERVE	7.08	5.05	0.97	13.10	1	090
64766		A	INCISE HIP/THIGH NERVE	8.75	7.03	1.27	17.05	1	090
64771		A	SEVER CRANIAL NERVE	7.36	6.77	0.77	14.90	1	090
64772		A	INCISION OF SPINAL NERVE	7.16	7.14	1.37	15.67	1	090
64774		A	REMOVE SKIN NERVE LESION	5.11	2.89	0.48	8.48	1	090
64776		A	REMOVE DIGIT NERVE LESION	5.11	2.93	0.43	8.47	2	090
64778		A	ADDED DIGIT NERVE SURGERY	3.27	2.88	0.45	6.60	2	ZZZ

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
64782		A	REMOVE LIMB NERVE LESION	6.12	4.95	0.49	11.56	1	090
64783		A	ADDED LIMB NERVE SURGERY	3.92	3.44	0.50	7.86	1	222
64784		A	REMOVE NERVE LESION	9.98	5.95	1.01	16.94	1	090
64786		A	REMOVE SCIATIC NERVE LESION	15.91	13.34	2.25	31.50	1	090
64787		A	IMPLANT NERVE END	4.54	3.66	0.64	8.84	1	222
64788		A	REMOVE SKIN NERVE LESION	4.54	3.83	0.53	8.90	1	090
64790		A	REMOVAL OF NERVE LESION	11.54	7.49	1.29	20.32	1	090
64792		A	REMOVAL OF NERVE LESION	15.17	9.47	1.75	26.39	1	090
64795		A	BIOPSY OF NERVE	3.17	2.51	0.41	6.09	2	000
64802		A	REMOVE SYMPATHETIC NERVES	8.66	5.69	1.15	15.50	1	090
64804		A	REMOVE SYMPATHETIC NERVES	14.38	13.45	2.57	30.40	1	090
64809		A	REMOVE SYMPATHETIC NERVES	13.47	11.12	2.15	26.74	1	090
64818		A	REMOVE SYMPATHETIC NERVES	9.93	9.03	1.81	20.77	1	090
64830		A	MICROREPAIR OF NERVE	3.26	2.12	0.39	5.77	2	222
64831		A	REPAIR OF DIGIT NERVE	9.32	3.56	0.60	13.48	2	090
64832		A	REPAIR ADDITIONAL NERVE	5.97	1.48	0.25	7.70	2	222
64834		A	REPAIR OF HAND OR FOOT NERVE	10.30	3.69	0.60	14.59	2	090
64835		A	REPAIR OF HAND OR FOOT NERVE	11.04	6.29	1.08	18.41	2	090
64836		A	REPAIR OF HAND OR FOOT NERVE	11.04	7.06	1.29	19.39	2	090
64837		A	REPAIR ADDITIONAL NERVE	6.59	4.69	0.90	12.18	2	222
64840		A	REPAIR OF LEG NERVE	13.10	10.91	0.57	24.58	1	090
64856		A	REPAIR/TRANSPOSE NERVE	13.50	8.65	1.54	23.69	1	090
64857		A	REPAIR ARM/LEG NERVE	14.15	11.42	1.96	27.53	1	090
64858		A	REPAIR SCIATIC NERVE	16.26	11.57	2.22	30.05	1	090
64859		A	ADDITIONAL NERVE SURGERY	4.49	3.69	0.62	8.80	1	222
64861		A	REPAIR OF ARM NERVES	18.91	14.14	1.46	34.51	1	090
64862		A	REPAIR OF LOW BACK NERVES	19.11	22.72	1.70	43.53	1	090
64864		A	REPAIR OF FACIAL NERVE	12.51	10.16	1.32	23.99	1	090
64865		A	REPAIR OF FACIAL NERVE	15.49	13.00	1.58	30.07	1	090
64866		A	FUSION OF FACIAL/OTHER NERVE	15.75	11.79	1.93	29.47	1	090
64868		A	FUSION OF FACIAL/OTHER NERVE	14.08	11.79	1.55	27.42	1	090
64870		A	FUSION OF FACIAL/OTHER NERVE	16.01	14.66	1.79	32.46	1	090
64872		C	SUBSEQUENT REPAIR OF NERVE	0.00	0.00	0.00	0.00		222
64874		C	REPAIR & REVISE NERVE	0.00	0.00	0.00	0.00		222
64876		C	REPAIR NERVE; SHORTEN BONE	0.00	0.00	0.00	0.00		222
64885		A	NERVE GRAFT, HEAD OR NECK	17.63	13.37	1.56	32.56	2	222
64886		A	NERVE GRAFT, HEAD OR NECK	21.03	15.94	1.86	38.83	2	222
64890		A	NERVE GRAFT, HAND OR FOOT	15.12	12.92	2.23	30.27	1	090
64891		A	NERVE GRAFT, HAND OR FOOT	16.03	10.99	1.82	28.84	2	090
64892		A	NERVE GRAFT, ARM OR LEG	14.59	11.63	1.78	28.00	2	090
64893		A	NERVE GRAFT, ARM OR LEG	15.39	14.68	2.40	32.47	2	090
64895		A	NERVE GRAFT, HAND OR FOOT	19.37	13.88	2.68	35.93	2	090
64896		A	NERVE GRAFT, HAND OR FOOT	20.43	18.47	2.01	40.91	2	090
64897		A	NERVE GRAFT, ARM OR LEG	18.31	13.31	2.60	34.22	2	090
64898		A	NERVE GRAFT, ARM OR LEG	19.37	15.17	2.48	37.02	2	090
64901		A	ADDITIONAL NERVE GRAFT	10.77	10.71	0.92	22.40	2	222
64902		A	ADDITIONAL NERVE GRAFT	12.47	12.56	1.04	26.07	2	222
64905		A	NERVE PEDICLE TRANSFER	13.94	9.91	0.74	24.59	1	090
64907		A	NERVE PEDICLE TRANSFER	18.86	13.71	2.68	35.25	1	090
64999		C	NERVOUS SYSTEM SURGERY	0.00	0.00	0.00	0.00		YYY
65091		A	REVISE EYE	6.43	9.09	0.48	16.00	1	090
65093		A	REVISE EYE WITH IMPLANT	6.82	10.54	0.56	17.92	1	090
65101		A	REMOVAL OF EYE	6.87	9.18	0.50	16.55	1	090
65103		A	REMOVE EYE/INSERT IMPLANT	7.44	10.23	0.54	18.21	1	090
65105		A	REMOVE EYE/ATTACH IMPLANT	8.24	10.96	0.59	19.79	1	090
65110		A	REMOVAL OF EYE	13.90	16.85	1.20	31.95	1	090
65112		A	REMOVE EYE, REVISE SOCKET	16.27	12.82	1.14	30.23	1	090
65114		A	REMOVE EYE, REVISE SOCKET	17.48	13.77	1.74	32.99	1	090
65125		C	REVISE OCULAR IMPLANT	0.00	0.00	0.00	0.00		YYY
65130		A	INSERT OCULAR IMPLANT	7.12	9.26	0.53	16.91	1	090
65135		A	INSERT OCULAR IMPLANT	7.30	5.71	0.36	13.37	1	090
65140		A	ATTACH OCULAR IMPLANT	7.86	6.55	0.34	14.75	1	090
65150		A	REVISE OCULAR IMPLANT	6.30	11.47	0.60	18.37	1	090
65155		A	REINSERT OCULAR IMPLANT	8.65	14.77	0.95	24.37	1	090
65175		A	REMOVAL OF OCULAR IMPLANT	6.25	7.89	0.42	14.56	1	090
65205		A	REMOVE FOREIGN BODY FROM EYE	1.04	0.38	0.02	1.44	2	010
65210		A	REMOVE FOREIGN BODY FROM EYE	1.21	0.49	0.03	1.73	2	010
65220		A	REMOVE FOREIGN BODY FROM EYE	0.97	0.56	0.04	1.57	2	010

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCP*CS	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
65222		A	REMOVE FOREIGN BODY FROM EYE	1.20	0.61	0.03	1.84	2	010
65235		A	REMOVE FOREIGN BODY FROM EYE	7.20	5.90	0.31	13.41	1	090
65260		A	REMOVE FOREIGN BODY FROM EYE	10.91	9.09	0.47	20.47	1	090
65265		A	REMOVE FOREIGN BODY FROM EYE	12.68	10.57	0.55	23.80	1	090
65270		A	REPAIR OF EYE WOUND	1.94	1.23	0.07	3.24	2	010
65272		A	REPAIR OF EYE WOUND	3.76	3.17	0.17	7.10	1	090
65273		A	REPAIR OF EYE WOUND	4.09	3.39	0.22	7.70	1	090
65275		A	REPAIR OF EYE WOUND	5.32	0.70	0.04	6.06	1	090
65280		A	REPAIR OF EYE WOUND	7.48	9.71	0.52	17.71	1	090
65285		A	REPAIR OF EYE WOUND	12.70	12.92	0.68	26.30	1	090
65286		A	REPAIR OF EYE WOUND	5.44	5.04	0.26	10.74	1	090
65290		A	REPAIR OF EYE SOCKET WOUND	5.34	6.53	0.38	12.25	1	090
65400		A	REMOVAL OF EYE LESION	5.90	6.81	0.36	13.07	1	090
65410		A	BIOPSY OF CORNEA	1.55	1.68	0.11	3.34	2	000
65420		A	REMOVAL OF EYE LESION	4.18	4.52	0.24	8.94	1	090
65426		A	REMOVAL OF EYE LESION	5.33	7.56	0.40	13.29	1	090
65430		A	CORNEAL SMEAR	0.92	0.58	0.03	1.53	2	000
65435		A	CURETTE/TREAT CORNEA	0.97	0.81	0.04	1.82	2	000
65436		A	CURETTE/TREAT CORNEA	2.92	1.62	0.08	4.62	1	090
65450		A	TREATMENT OF CORNEAL LESION	3.23	3.46	0.18	6.87	1	090
65600		A	REVISION OF CORNEA	3.31	2.76	0.14	6.21	1	090
65710		A	CORNEAL TRANSPLANT	10.04	22.39	1.18	33.61	1	090
65730		A	CORNEAL TRANSPLANT	12.47	26.04	1.36	39.87	1	090
65750		A	CORNEAL TRANSPLANT	13.26	26.80	1.40	41.46	1	090
65755		A	CORNEAL TRANSPLANT	11.99	9.99	0.52	22.50	1	090
65760		N	REVISION OF CORNEA	0.00	0.00	0.00	0.00		XXX
65765		N	REVISION OF CORNEA	0.00	0.00	0.00	0.00		XXX
65767		N	CORNEAL TISSUE TRANSPLANT	0.00	0.00	0.00	0.00		XXX
65770		A	REVISE CORNEA WITH IMPLANT	17.45	14.54	0.75	32.74	1	090
65771		N	RADIAL KERATOTOMY	0.00	0.00	0.00	0.00		XXX
65772		A	CORRECTION OF ASTIGMATISM	4.25	6.18	0.32	10.75	1	090
65775		A	CORRECTION OF ASTIGMATISM	5.73	10.32	0.54	16.59	1	090
65800		A	DRAINAGE OF EYE	2.02	1.81	0.10	3.93	2	000
65805		A	DRAINAGE OF EYE	2.02	1.90	0.10	4.02	2	000
65810		A	DRAINAGE OF EYE	4.81	5.74	0.31	10.86	1	090
65815		A	DRAINAGE OF EYE	5.00	4.73	0.25	9.98	1	090
65820		A	RELIEVE INNER EYE PRESSURE	6.43	10.06	0.55	17.04	1	090
65850		A	INCISION OF EYE	7.90	13.98	0.73	22.61	1	090
65855		A	LASER SURGERY OF EYE	4.90	10.65	0.56	16.11	1	090
65865		A	INCISE INNER EYE ADHESIONS	5.71	7.91	0.43	14.05	1	090
65870		A	INCISE INNER EYE ADHESIONS	6.24	6.18	0.32	12.74	1	090
65875		A	INCISE INNER EYE ADHESIONS	6.47	6.61	0.35	13.43	1	090
65880		A	INCISE INNER EYE ADHESIONS	7.05	7.22	0.38	14.65	1	090
65900		A	REMOVE EYE LESION	9.56	7.97	0.41	17.94	1	090
65920		A	REMOVE IMPLANT FROM EYE	8.33	8.80	0.46	17.59	1	090
65930		A	REMOVE BLOOD CLOT FROM EYE	7.41	8.10	0.43	15.94	1	090
66020		A	INJECTION TREATMENT OF EYE	1.63	2.64	0.14	4.41	1	010
66030		A	INJECTION TREATMENT OF EYE	1.27	0.58	0.03	1.88	2	010
66130		A	REMOVE EYE LESION	3.97	5.56	0.29	9.82	1	090
66150		A	INCISION OF EYE	8.00	11.64	0.63	20.27	1	090
66155		A	INCISION OF EYE	7.88	10.30	0.54	18.72	1	090
66160		A	INCISION OF EYE	9.99	11.35	0.59	21.93	1	090
66165		A	INCISION OF EYE	7.70	11.51	0.61	19.82	1	090
66170		A	INCISION OF EYE	9.71	12.81	0.67	23.19	1	090
66180		A	IMPLANT EYE SHUNT	11.38	9.48	0.49	21.35	1	090
66185		A	REVISE EYE SHUNT	8.11	6.76	0.35	15.22	1	090
66220		A	REPAIR EYE LESION	7.71	6.27	0.35	14.33	1	090
66225		A	REPAIR/GRAFT EYE LESION	11.12	17.64	0.91	29.67	1	090
66250		A	FOLLOW-UP SURGERY OF EYE	5.92	7.67	0.40	13.99	1	090
66500		A	INCISION OF IRIS	3.78	5.26	0.28	9.32	1	090
66505		A	INCISION OF IRIS	4.14	3.45	0.18	7.77	1	090
66600		A	REMOVE IRIS AND LESION	8.67	9.85	0.55	19.07	1	090
66605		A	REMOVAL OF IRIS	8.68	12.51	0.71	21.90	1	090
66625		A	REMOVAL OF IRIS	5.21	9.77	0.51	15.49	1	090
66630		A	REMOVAL OF IRIS	6.12	9.13	0.48	15.73	1	090
66635		A	REMOVAL OF IRIS	6.22	10.06	0.52	16.80	1	090
66680		A	REPAIR IRIS & CILIARY BODY	5.42	6.77	0.36	12.55	1	090
66682		A	REPAIR IRIS AND CILIARY BODY	6.18	7.72	0.40	14.30	1	090

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
66700		A	DESTRUCTION, CILIARY BODY	4.79	6.83	0.36	11.98	2	090
66702		D	CILIARY BODY DESTRUCTION, ANY METH	0.00	0.00	0.00	0.00		XXX
66710		A	DESTRUCTION, CILIARY BODY	4.79	3.63	0.42	8.84	2	090
66720		A	DESTRUCTION, CILIARY BODY	4.79	7.48	0.39	12.66	1	090
66740		A	DESTRUCTION, CILIARY BODY	4.79	7.90	0.41	13.10	2	090
66761		A	REVISION OF IRIS	3.97	9.66	0.50	14.13	2	090
66762		A	REVISION OF IRIS	4.57	11.30	0.59	16.46	2	090
66770		A	REMOVAL OF INNER EYE LESION	5.13	9.19	0.48	14.80	1	090
66820		A	INCISION, SECONDARY CATARACT	3.96	5.74	0.30	10.00	1	090
66821		A	LASERING, SECONDARY CATARACT	2.93	7.23	0.38	10.54	1	090
66830		A	REMOVAL OF LENS LESION	8.22	8.09	0.42	16.73	1	090
66840		A	REMOVAL OF LENS MATERIAL	7.91	10.88	0.58	19.37	1	090
66850		A	REMOVAL OF LENS MATERIAL	9.13	13.58	0.74	23.45	1	090
66852		A	REMOVAL OF LENS MATERIAL	10.04	8.36	0.43	18.83	1	090
66920		A	EXTRACTION OF LENS	8.91	11.74	0.64	21.29	1	090
66930		A	EXTRACTION OF LENS	10.26	11.06	0.61	21.93	1	090
66940		A	EXTRACTION OF LENS	8.93	12.44	0.66	22.03	1	090
66983		A	REMOVE CATARACT, INSERT LENS	9.00	18.81	1.00	28.81	2	090
66984		A	REMOVE CATARACT, INSERT LENS	10.42	18.93	0.99	30.34	2	090
66985		A	INSERT LENS PROSTHESIS	8.32	12.86	0.67	21.85	1	090
66986		A	EXCHANGE LENS PROSTHESIS	12.42	10.34	0.54	23.30	2	090
66999		C	EYE SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
67005		A	PARTIAL REMOVAL OF EYE FLUID	6.98	22.36	1.18	30.52	1	090
67010		A	PARTIAL REMOVAL OF EYE FLUID	7.03	20.95	1.09	29.07	1	090
67015		A	RELEASE OF EYE FLUID	7.05	6.80	0.36	14.21	1	090
67025		A	REPLACE EYE FLUID	6.79	7.12	0.37	14.28	1	090
67028		A	INJECTION EYE DRUG	2.65	2.21	0.11	4.97	2	000
67030		A	INCISE INNER EYE STRANDS	4.68	10.21	0.53	15.42	1	090
67031		A	LASER SURGERY, EYE STRANDS	3.61	15.11	0.79	19.51	2	090
67036		A	REMOVAL OF INNER EYE FLUID	11.94	30.17	1.57	43.68	1	090
67038		A	STRIP RETINAL MEMBRANE	21.28	36.16	1.89	59.33	1	090
67039		A	LASER TREATMENT OF RETINA	14.33	11.94	0.62	26.89	2	090
67040		A	LASER TREATMENT OF RETINA	17.14	35.27	1.84	54.25	1	090
67101		A	REPAIR, DETACHED RETINA	7.40	13.34	0.70	21.44	1	090
67105		A	REPAIR, DETACHED RETINA	7.44	16.19	0.84	24.47	1	090
67107		A	REPAIR DETACHED RETINA	14.75	22.00	1.15	37.90	1	090
67108		A	REPAIR DETACHED RETINA	20.97	35.34	1.85	58.16	1	090
67109		A	REPAIR DETACHED RETINA	12.13	22.42	1.17	35.72	1	090
67110		A	REPAIR DETACHED RETINA	8.58	7.14	0.37	16.09	1	090
67112		A	RE-REPAIR DETACHED RETINA	17.02	17.39	0.91	35.32	1	090
67115		A	RELEASE, ENCIRCLING MATERIAL	4.89	8.52	0.46	13.87	1	090
67120		A	REMOVE EYE IMPLANT MATERIAL	5.93	7.54	0.39	13.86	1	090
67121		A	REMOVE EYE IMPLANT MATERIAL	10.72	9.93	0.52	21.17	1	090
67141		A	TREATMENT OF RETINA	5.16	9.78	0.51	15.45	1	090
67145		A	TREATMENT OF RETINA	5.35	9.92	0.52	15.79	1	090
67208		A	TREATMENT OF RETINAL LESION	6.75	10.73	0.56	18.04	2	090
67210		A	TREATMENT OF RETINAL LESION	6.75	9.50	0.50	16.75	1	090
67218		A	TREATMENT OF RETINAL LESION	13.41	14.03	0.74	28.18	1	090
67227		A	TREATMENT OF RETINAL LESION	6.61	10.48	0.55	17.64	1	090
67228		A	TREATMENT OF RETINAL LESION	6.88	9.88	0.51	17.27	1	090
67250		A	REINFORCE EYE WALL	8.80	7.36	0.42	16.58	1	090
67255		A	REINFORCE/GRAFT EYE WALL	8.84	17.73	0.92	27.49	1	090
67299		C	EYE SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
67311		A	REVISE EYE MUSCLE	6.63	9.50	0.50	16.63	1	090
67312		A	REVISE TWO EYE MUSCLES	7.95	10.88	0.57	19.40	1	090
67314		A	REVISE EYE MUSCLE	6.87	5.72	0.30	12.89	1	090
67316		A	REVISE TWO EYE MUSCLES	8.46	7.05	0.37	15.88	1	090
67318		A	REVISE EYE MUSCLE(S)	7.85	6.54	0.34	14.73	1	090
67320		A	REVISE EYE MUSCLE(S)	8.70	13.18	0.73	22.61	1	090
67331		A	EYE SURGERY FOLLOW-UP	8.14	10.70	0.58	19.42	1	090
67332		A	REREVISE EYE MUSCLES	9.05	11.76	0.62	21.43	1	090
67334		A	REVISE EYE MUSCLE W/SUTURE	7.96	6.63	0.34	14.93	1	090
67335		A	EYE SUTURE DURING SURGERY	1.06	8.51	0.45	10.02	2	ZZZ
67340		A	REVISE EYE MUSCLE	9.97	8.30	0.43	18.70	1	090
67343		A	RELEASE EYE TISSUE	7.38	6.14	0.32	13.84	1	090
67345		A	DESTROY NERVE OF EYE MUSCLE	2.32	1.94	0.10	4.36	1	090
67350		A	BIOPSY EYE MUSCLE	3.02	2.52	0.13	5.67	2	000
67399		C	EYE MUSCLE SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
67400		A	EXPLORE/BIOPSY EYE SOCKET	9.69	11.50	0.66	21.85	1	090
67405		A	EXPLORE/DRAIN EYE SOCKET	7.82	10.55	0.71	19.08	1	090
67412		A	EXPLORE/TREAT EYE SOCKET	9.63	12.57	0.71	22.91	1	090
67413		A	EXPLORE/TREAT EYE SOCKET	10.28	8.53	0.61	19.42	1	090
67414		A	EXPLORE/DECOMPRESS EYESOCKET	10.61	8.84	0.46	19.91	2	090
67415		A	BIOPSY OF EYE	1.85	2.13	0.12	4.10	2	000
67420		A	EXPLORE/TREAT EYE SOCKET	14.08	17.68	1.16	32.92	1	090
67430		A	EXPLORE/TREAT EYE SOCKET	13.47	11.22	0.58	25.27	1	090
67440		A	EXPLORE/DRAIN EYE SOCKET	13.10	17.00	1.02	31.12	1	090
67445		A	EXPLORE/DECOMPRESS EYESOCKET	14.08	11.73	0.61	26.42	2	090
67450		A	EXPLORE/BIOPSY EYE SOCKET	13.49	16.11	0.92	30.52	1	090
67500		A	INJECT/TREAT EYE SOCKET	0.83	0.77	0.06	1.66	2	000
67505		A	INJECT/TREAT EYE SOCKET	0.86	1.09	0.06	2.01	2	000
67515		A	INJECT/TREAT EYE SOCKET	0.65	0.60	0.03	1.28	2	000
67550		A	INSERT EYE SOCKET IMPLANT	10.21	10.14	0.74	21.09	1	090
67560		A	REVISE EYE SOCKET IMPLANT	10.64	8.74	0.51	19.89	1	090
67570		A	DECOMPRESS OPTIC NERVE	9.55	7.96	0.41	17.92	2	090
67599		C	ORBIT SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
67700		A	DRAINAGE OF EYELID ABSCESS	1.37	0.52	0.03	1.92	2	010
67710		A	INCISION OF EYELID	1.02	1.06	0.06	2.14	2	010
67715		A	INCISION OF EYELID FOLD	1.23	1.59	0.09	2.91	2	010
67800		A	REMOVE EYELID LESION	1.43	0.99	0.05	2.47	1	010
67801		A	REMOVE EYELID LESIONS	1.94	1.47	0.08	3.49	1	010
67805		A	REMOVE EYELID LESIONS	2.28	1.46	0.08	3.82	1	010
67808		A	REMOVE EYELID LESION(S)	3.74	2.24	0.13	6.11	1	090
67810		A	BIOPSY OF EYELID	1.56	0.85	0.05	2.46	2	000
67820		A	REVISE EYELASHES	0.94	0.39	0.02	1.35	2	010
67825		A	REVISE EYELASHES	1.40	0.95	0.05	2.40	2	010
67830		A	REVISE EYELASHES	1.74	3.26	0.17	5.17	1	010
67835		A	REVISE EYELASHES	5.70	8.95	0.48	15.13	1	090
67840		A	REMOVE EYELID LESION	2.10	1.29	0.07	3.46	2	010
67850		A	TREAT EYELID LESION	1.73	0.86	0.05	2.64	2	010
67875		A	CLOSURE OF EYELID BY SUTURE	1.42	1.18	0.06	2.66	2	000
67880		A	REVISION OF EYELID	3.74	4.15	0.24	8.13	1	090
67882		A	REVISION OF EYELID	5.02	6.66	0.38	12.06	1	090
67900		A	REPAIR BROW DEFECT	4.78	3.98	0.21	8.97	2	090
67901		A	REPAIR EYELID DEFECT	7.19	10.48	0.68	18.35	1	090
67902		A	REPAIR EYELID DEFECT	7.25	11.27	0.76	19.28	1	090
67903		A	REPAIR EYELID DEFECT	6.55	12.93	0.77	20.25	1	090
67904		A	REPAIR EYELID DEFECT	6.29	12.63	0.75	19.67	1	090
67906		A	REPAIR EYELID DEFECT	6.99	5.75	0.37	13.11	1	090
67907		D	REPAIR EYELID DEFECT	0.00	0.00	0.00	0.00		XXX
67908		A	REPAIR EYELID DEFECT	5.23	10.63	0.58	16.44	1	090
67909		A	REVISE EYELID DEFECT	5.50	8.06	0.51	14.07	1	090
67911		A	REVISE EYELID DEFECT	5.37	11.62	0.83	17.82	1	090
67914		A	REPAIR EYELID DEFECT	3.80	7.10	0.41	11.31	1	090
67915		A	REPAIR EYELID DEFECT	3.26	1.32	0.07	4.65	1	090
67916		A	REPAIR EYELID DEFECT	5.41	6.85	0.40	12.66	1	090
67917		A	REPAIR EYELID DEFECT	6.16	8.43	0.50	15.09	1	090
67921		A	REPAIR EYELID DEFECT	3.50	4.02	0.21	7.73	1	090
67922		A	REPAIR EYELID DEFECT	3.14	1.25	0.07	4.46	1	090
67923		A	REPAIR EYELID DEFECT	6.01	7.25	0.39	13.65	1	090
67924		A	REPAIR EYELID DEFECT	5.95	8.37	0.45	14.77	1	090
67930		A	REPAIR EYELID WOUND	3.75	1.34	0.08	5.17	1	010
67935		A	REPAIR EYELID WOUND	6.40	3.99	0.25	10.64	1	090
67938		A	REMOVE EYELID FOREIGN BODY	1.35	0.56	0.03	1.94	1	010
67950		A	REVISION OF EYELID	5.95	8.18	0.48	14.61	1	090
67961		A	REVISION OF EYELID	5.80	8.22	0.53	14.55	1	090
67966		A	REVISION OF EYELID	6.74	10.90	0.70	18.34	1	090
67971		A	RECONSTRUCTION OF EYELID	10.08	11.25	0.68	22.01	1	090
67973		A	RECONSTRUCTION OF EYELID	13.27	14.27	0.96	28.50	1	090
67974		A	RECONSTRUCTION OF EYELID	13.24	14.83	0.92	28.99	1	090
67975		A	RECONSTRUCTION OF EYELID	9.38	4.38	0.25	14.01	1	090
67999		C	EYELID SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
68020		A	INCISE/DRAIN EYELID LINING	1.39	0.55	0.03	1.97	1	010
68040		A	TREATMENT OF EYELID LESIONS	0.89	0.47	0.02	1.38	1	010
68100		A	BIOPSY OF EYELID LINING	1.43	1.04	0.06	2.53	2	000
68110		A	REMOVE EYELID LINING LESION	1.81	1.31	0.07	3.19	1	010

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
68115		A	REMOVE EYELID LINING LESION	2.44	2.04	0.11	4.59	1	010
68130		A	REMOVE EYELID LINING LESION	5.00	4.31	0.23	9.54	1	090
68135		A	REMOVE EYELID LINING LESION	1.88	0.78	0.04	2.70	2	010
68200		A	TREAT EYELID BY INJECTION	0.52	0.56	0.03	1.11	2	000
68320		A	REVISE/GRAFT EYELID LINING	5.25	8.19	0.44	13.88	1	090
68325		A	REVISE/GRAFT EYELID LINING	7.33	10.67	0.66	18.66	1	090
68326		A	REVISE/GRAFT EYELID LINING	7.12	9.08	0.52	16.72	1	090
68328		A	REVISE/GRAFT EYELID LINING	8.20	12.50	0.86	21.56	1	090
68330		A	REVISE EYELID LINING	4.77	6.78	0.36	11.91	1	090
68335		A	REVISE/GRAFT EYELID LINING	7.16	5.90	0.40	13.46	1	090
68340		A	SEPARATE EYELID ADHESIONS	4.12	3.30	0.17	7.59	1	090
68360		A	REVISE EYELID LINING	4.34	6.23	0.34	10.91	1	090
68362		A	REVISE EYELID LINING	7.31	8.45	0.44	16.20	1	090
68399		C	EYELID LINING SURGERY	0.00	0.00	0.00	0.00		YYY
68400		A	INCISE/DRAIN TEAR GLAND	1.73	1.05	0.06	2.84	1	010
68420		A	INCISE/DRAIN TEAR SAC	2.37	1.07	0.06	3.50	1	010
68440		A	INCISE TEAR DUCT OPENING	0.94	0.80	0.04	1.78	2	010
68500		A	REMOVAL OF TEAR GLAND	11.04	8.01	0.79	19.84	1	090
68505		A	PARTIAL REMOVAL TEAR GLAND	10.95	9.17	0.52	20.64	1	090
68510		A	BIOPSY OF TEAR GLAND	4.86	3.89	0.29	9.04	2	000
68520		A	REMOVAL OF TEAR SAC	7.49	9.72	0.55	17.76	1	090
68525		A	BIOPSY OF TEAR SAC	4.67	3.88	0.24	8.79	2	000
68530		A	CLEARANCE OF TEAR DUCT	3.81	3.00	0.17	6.98	1	010
68540		A	REMOVE TEAR GLAND LESION	10.64	8.75	0.53	19.92	1	090
68550		A	REMOVE TEAR GLAND LESION	13.34	11.95	0.78	26.07	1	222
68700		A	REPAIR TEAR DUCTS	6.53	2.84	0.15	9.52	1	090
68705		A	REVISE TEAR DUCT OPENING	2.12	1.07	0.05	3.24	1	010
68720		A	CREATE TEAR SAC DRAIN	8.10	13.39	0.78	22.27	1	090
68745		A	CREATE TEAR DUCT DRAIN	8.67	6.91	0.48	16.06	1	090
68750		A	CREATE TEAR DUCT DRAIN	8.65	15.57	0.87	25.09	1	090
68760		A	CLOSE TEAR DUCT OPENING	1.77	0.97	0.04	2.78	1	010
68770		A	CLOSE TEAR SYSTEM FISTULA	6.97	4.47	0.24	11.68	1	090
68800		A	DILATE TEAR DUCT OPENING(S)	1.16	0.44	0.02	1.62	2	010
68820		A	EXPLORE TEAR DUCT SYSTEM	1.55	0.59	0.03	2.17	2	010
68825		A	EXPLORE TEAR DUCT SYSTEM	1.62	1.57	0.09	3.28	1	010
68830		A	REOPEN TEAR DUCT CHANNEL	2.23	2.04	0.10	4.37	1	010
68840		A	EXPLORE/IRRIGATE TEAR DUCTS	1.29	0.52	0.03	1.84	2	010
68850		A	INJECTION FOR TEAR SAC X-RAY	0.84	0.55	0.04	1.43	2	000
68899		C	TEAR DUCT SYSTEM SURGERY	0.00	0.00	0.00	0.00		YYY
69000		A	DRAIN EXTERNAL EAR LESION	1.48	0.36	0.03	1.87	2	010
69005		A	DRAIN EXTERNAL EAR LESION	2.17	1.22	0.13	3.52	1	010
69020		A	DRAIN OUTER EAR CANAL LESION	1.51	0.47	0.04	2.02	2	010
69090		N	PIERCE EARLOBES	0.00	0.00	0.00	0.00		XXX
69100		A	BIOPSY OF EXTERNAL EAR	0.80	0.70	0.07	1.57	2	000
69105		A	BIOPSY OF EXTERNAL EAR CANAL	0.90	0.84	0.09	1.83	2	000
69110		A	PARTIAL REMOVAL EXTERNAL EAR	3.52	2.77	0.38	6.67	1	090
69120		A	REMOVAL OF EXTERNAL EAR	4.16	0.82	0.07	5.05	1	090
69140		A	REMOVE EAR CANAL LESION(S)	7.21	8.43	0.93	16.57	1	090
69145		A	REMOVE EAR CANAL LESION(S)	2.67	2.64	0.29	5.60	1	090
69150		A	EXTENSIVE EAR CANAL SURGERY	13.70	11.03	1.32	26.05	1	090
69155		A	EXTENSIVE EAR/NECK SURGERY	17.95	16.78	1.70	36.43	2	090
69200		A	CLEAR OUTER EAR CANAL	0.81	0.44	0.04	1.29	2	010
69205		A	CLEAR OUTER EAR CANAL	1.21	1.12	0.11	2.44	1	010
69210		A	REMOVE IMPACTED EAR WAX	0.65	0.24	0.02	0.91	2	000
69220		A	CLEAN OUT MASTOID CAVITY	0.87	0.53	0.05	1.45	2	010
69222		A	CLEAN OUT MASTOID CAVITY	1.43	0.78	0.08	2.29	1	010
69300		N	REVISE EXTERNAL EAR	0.00	0.00	0.00	0.00		XXX
69310		A	REBUILD OUTER EAR CANAL	11.16	10.37	1.13	22.66	1	090
69320		A	REBUILD OUTER EAR CANAL	17.49	15.43	1.75	34.67	1	090
69399		C	OUTER EAR SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
69400		A	INFLATE MIDDLE EAR CANAL	0.87	0.47	0.05	1.39	1	010
69401		A	INFLATE MIDDLE EAR CANAL	0.67	0.26	0.03	0.96	1	010
69405		A	CATHETERIZE MIDDLE EAR CANAL	2.72	0.51	0.04	3.27	1	010
69410		A	INSET MIDDLE EAR BAFFLE	0.34	0.64	0.07	1.05	2	000
69420		A	INCISION OF EARDRUM	1.35	0.73	0.08	2.16	2	010
69421		A	INCISION OF EARDRUM	1.77	1.20	0.13	3.10	2	010
69424		A	REMOVE VENTILATING TUBE	0.90	0.64	0.06	1.60	2	000
69433		A	CREATE EARDRUM OPENING	1.55	1.40	0.15	3.10	2	010

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
69436		A	CREATE EARDRUM OPENING	2.02	2.24	0.24	4.50	2	010
69440		A	EXPLORATION OF MIDDLE EAR	7.70	9.16	0.98	17.84	1	090
69450		A	EARDRUM REVISION	5.73	5.14	0.55	11.42	1	090
69501		A	MASTOIDECTOMY	9.29	11.49	1.23	22.01	1	090
69502		A	MASTOIDECTOMY	12.60	14.08	1.53	28.21	1	090
69505		A	REMOVE MASTOID STRUCTURES	13.25	17.20	1.88	32.33	1	090
69511		A	EXTENSIVE MASTOID SURGERY	13.80	17.95	1.93	33.68	2	090
69530		A	EXTENSIVE MASTOID SURGERY	19.01	17.61	1.81	38.43	1	090
69535		A	REMOVE PART OF TEMPORAL BONE	36.35	26.63	3.00	65.98	1	090
69540		A	REMOVE EAR LESION	1.21	1.34	0.14	2.69	1	010
69550		A	REMOVE EAR LESION	11.27	10.08	1.08	22.43	1	090
69552		A	REMOVE EAR LESION	19.85	17.63	1.95	39.43	2	090
69554		A	REMOVE EAR LESION	27.17	24.09	2.78	54.04	1	090
69601		A	MASTOID SURGERY REVISION	13.48	14.78	1.64	29.90	1	090
69602		A	MASTOID SURGERY REVISION	13.88	17.15	1.84	32.87	1	090
69603		A	MASTOID SURGERY REVISION	14.33	18.27	1.97	34.57	2	090
69604		A	MASTOID SURGERY REVISION	14.33	27.20	2.85	44.38	2	090
69605		A	MASTOID SURGERY REVISION	19.01	15.76	1.95	36.72	2	090
69610		A	REPAIR OF EARDRUM	4.62	0.98	0.10	5.70	1	090
69620		A	REPAIR OF EARDRUM	6.05	11.53	1.22	18.80	1	090
69631		A	REPAIR EARDRUM STRUCTURES	10.07	15.90	1.70	27.67	1	090
69632		A	REBUILD EARDRUM STRUCTURES	13.08	16.94	1.82	31.84	1	090
69633		A	REBUILD EARDRUM STRUCTURES	12.40	17.65	1.87	31.92	1	090
69635		A	REPAIR EARDRUM STRUCTURES	13.71	18.86	2.02	34.59	1	090
69636		A	REBUILD EARDRUM STRUCTURES	15.69	20.50	2.22	38.41	1	090
69637		A	REBUILD EARDRUM STRUCTURES	15.56	21.87	2.33	39.76	1	090
69641		A	REVISE MIDDLE EAR & MASTOID	12.95	18.59	1.96	33.50	1	090
69642		A	REVISE MIDDLE EAR & MASTOID	17.25	21.72	2.32	41.29	1	090
69643		A	REVISE MIDDLE EAR & MASTOID	15.60	23.51	2.64	41.75	1	090
69644		A	REVISE MIDDLE EAR & MASTOID	17.34	26.22	2.85	46.41	1	090
69645		A	REVISE MIDDLE EAR & MASTOID	16.65	24.80	2.64	44.09	1	090
69646		A	REVISE MIDDLE EAR & MASTOID	18.28	23.14	2.53	43.95	1	090
69650		A	RELEASE MIDDLE EAR BONE	9.91	13.43	1.40	24.74	1	090
69660		A	REVISE MIDDLE EAR BONE	12.27	17.77	1.91	31.95	1	090
69661		A	REVISE MIDDLE EAR BONE	16.14	19.44	2.04	37.62	1	090
69662		A	REVISE MIDDLE EAR BONE	15.85	14.80	1.57	32.22	1	090
69666		A	REPAIR MIDDLE EAR STRUCTURES	9.87	16.91	1.86	28.64	1	090
69667		A	REPAIR MIDDLE EAR STRUCTURES	9.89	16.58	1.75	28.22	1	090
69670		A	REMOVE MASTOID AIR CELLS	11.64	10.73	1.13	23.50	1	090
69676		A	REMOVE MIDDLE EAR NERVE	9.72	8.98	0.91	19.61	1	090
69700		A	CLOSE MASTOID FISTULA	8.40	8.28	0.88	17.56	1	090
69710		N	IMPLANT/REPLACE HEARING AID	0.00	0.00	0.00	0.00		XXX
69711		A	REMOVE/REPAIR HEARING AID	10.67	8.89	0.46	20.02	1	090
69720		A	RELEASE FACIAL NERVE	14.53	21.19	2.40	38.12	1	090
69725		A	RELEASE FACIAL NERVE	16.67	15.43	1.59	33.69	1	090
69740		A	REPAIR FACIAL NERVE	16.22	12.47	1.78	30.47	1	090
69745		A	REPAIR FACIAL NERVE	16.96	16.81	1.62	35.39	1	090
69799		C	MIDDLE EAR SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
69801		A	INCISE INNER EAR	8.63	17.49	1.93	28.05	1	090
69802		A	INCISE INNER EAR	13.11	11.85	1.29	26.25	1	090
69805		A	EXPLORE INNER EAR	10.82	9.67	1.06	21.55	1	090
69806		A	EXPLORE INNER EAR	12.46	24.31	2.67	39.44	1	090
69820		A	ESTABLISH INNER EAR WINDOW	10.69	9.33	1.05	21.07	1	090
69840		A	REVISE INNER EAR WINDOW	10.59	8.94	0.55	20.08	1	090
69905		A	REMOVE INNER EAR	11.27	19.37	2.18	32.82	1	090
69910		A	REMOVE INNER EAR & MASTOID	13.80	24.11	2.47	40.38	2	090
69915		A	INCISE INNER EAR NERVE	20.95	18.67	2.13	41.75	1	090
69930		A	IMPLANT COCHLEAR DEVICE	14.76	33.98	3.52	52.26	1	090
69949		C	INNER EAR SURGERY PROCEDURE	0.00	0.00	0.00	0.00		YYY
69950		A	INCISE INNER EAR NERVE	22.29	18.96	2.44	43.69	1	090
69955		A	RELEASE FACIAL NERVE	23.31	21.37	2.37	47.05	1	090
69960		A	RELEASE INNER EAR CANAL	20.81	18.81	2.04	41.66	1	090
69970		A	REMOVE INNER EAR LESION	23.50	20.75	2.39	46.64	1	090
69979		C	TEMPORAL BONE SURGERY	0.00	0.00	0.00	0.00		YYY
70010		A	CONTRAST X-RAY OF BRAIN	1.25	4.91	0.35	6.51	2	XXX
70010	TC	A	CONTRAST X-RAY OF BRAIN	0.00	4.35	0.27	4.62		XXX
70010	26	A	CONTRAST X-RAY OF BRAIN	1.25	0.56	0.08	1.89	2	XXX
70011		D	CONTRAST X-RAY OF BRAIN	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
70015		A	CONTRAST X-RAY OF BRAIN	1.25	1.92	0.17	3.34	2	XXX
70015	TC	A	CONTRAST X-RAY OF BRAIN	0.00	1.36	0.09	1.45		XXX
70015	26	A	CONTRAST X-RAY OF BRAIN	1.25	0.56	0.08	1.89	2	XXX
70016		D	CONTRAST X-RAY OF BRAIN	0.00	0.00	0.00	0.00		XXX
70030		A	X-RAY EYE FOR FOREIGN BODY	0.18	0.50	0.04	0.72	2	XXX
70030	TC	A	X-RAY EYE FOR FOREIGN BODY	0.00	0.42	0.03	0.45		XXX
70030	26	A	X-RAY EYE FOR FOREIGN BODY	0.18	0.08	0.01	0.27	2	XXX
70100		A	X-RAY EXAM OF JAW	0.19	0.62	0.04	0.85	2	XXX
70100	TC	A	X-RAY EXAM OF JAW	0.00	0.53	0.03	0.56		XXX
70100	26	A	X-RAY EXAM OF JAW	0.19	0.09	0.01	0.29	2	XXX
70110		A	X-RAY EXAM OF JAW	0.26	0.75	0.06	1.07	2	XXX
70110	TC	A	X-RAY EXAM OF JAW	0.00	0.63	0.04	0.67		XXX
70110	26	A	X-RAY EXAM OF JAW	0.26	0.12	0.02	0.40	2	XXX
70120		A	X-RAY EXAM OF MASTOIDS	0.19	0.72	0.05	0.96	2	XXX
70120	TC	A	X-RAY EXAM OF MASTOIDS	0.00	0.63	0.04	0.67		XXX
70120	26	A	X-RAY EXAM OF MASTOIDS	0.19	0.09	0.01	0.29	2	XXX
70130		A	X-RAY EXAM OF MASTOIDS	0.35	0.95	0.07	1.37	2	XXX
70130	TC	A	X-RAY EXAM OF MASTOIDS	0.00	0.79	0.05	0.84		XXX
70130	26	A	X-RAY EXAM OF MASTOIDS	0.35	0.16	0.02	0.53	2	XXX
70134		A	X-RAY EXAM OF MIDDLE EAR	0.35	0.90	0.07	1.32	2	XXX
70134	TC	A	X-RAY EXAM OF MIDDLE EAR	0.00	0.74	0.05	0.79		XXX
70134	26	A	X-RAY EXAM OF MIDDLE EAR	0.35	0.16	0.02	0.53	2	XXX
70140		A	X-RAY EXAM OF FACIAL BONES	0.20	0.72	0.05	0.97	2	XXX
70140	TC	A	X-RAY EXAM OF FACIAL BONES	0.00	0.63	0.04	0.67		XXX
70140	26	A	X-RAY EXAM OF FACIAL BONES	0.20	0.09	0.01	0.30	2	XXX
70150		A	X-RAY EXAM OF FACIAL BONES	0.27	0.91	0.07	1.25	2	XXX
70150	TC	A	X-RAY EXAM OF FACIAL BONES	0.00	0.79	0.05	0.84		XXX
70150	26	A	X-RAY EXAM OF FACIAL BONES	0.27	0.12	0.02	0.41	2	XXX
70160		A	X-RAY EXAM OF NASAL BONES	0.18	0.61	0.04	0.83	2	XXX
70160	TC	A	X-RAY EXAM OF NASAL BONES	0.00	0.53	0.03	0.56		XXX
70160	26	A	X-RAY EXAM OF NASAL BONES	0.18	0.08	0.01	0.27	2	XXX
70170		A	X-RAY EXAM OF TEAR DUCT	0.31	1.09	0.08	1.48	2	XXX
70170	TC	A	X-RAY EXAM OF TEAR DUCT	0.00	0.95	0.06	1.01		XXX
70170	26	A	X-RAY EXAM OF TEAR DUCT	0.31	0.14	0.02	0.47	2	XXX
70171		D	X-RAY EXAM OF TEAR DUCT	0.00	0.00	0.00	0.00		XXX
70190		A	X-RAY EXAM OF EYE SOCKETS	0.22	0.73	0.05	1.00	2	XXX
70190	TC	A	X-RAY EXAM OF EYE SOCKETS	0.00	0.63	0.04	0.67		XXX
70190	26	A	X-RAY EXAM OF EYE SOCKETS	0.22	0.10	0.01	0.33	2	XXX
70200		A	X-RAY EXAM OF EYE SOCKETS	0.29	0.92	0.07	1.28	2	XXX
70200	TC	A	X-RAY EXAM OF EYE SOCKETS	0.00	0.79	0.05	0.84		XXX
70200	26	A	X-RAY EXAM OF EYE SOCKETS	0.29	0.13	0.02	0.44	2	XXX
70210		A	X-RAY EXAM OF SINUSES	0.18	0.71	0.05	0.94	2	XXX
70210	TC	A	X-RAY EXAM OF SINUSES	0.00	0.63	0.04	0.67		XXX
70210	26	A	X-RAY EXAM OF SINUSES	0.18	0.08	0.01	0.27	2	XXX
70220		A	X-RAY EXAM OF SINUSES	0.26	0.91	0.07	1.24	2	XXX
70220	TC	A	X-RAY EXAM OF SINUSES	0.00	0.79	0.05	0.84		XXX
70220	26	A	X-RAY EXAM OF SINUSES	0.26	0.12	0.02	0.40	2	XXX
70240		A	X-RAY EXAM PITUITARY SADDLE	0.20	0.51	0.04	0.75	2	XXX
70240	TC	A	X-RAY EXAM PITUITARY SADDLE	0.00	0.42	0.03	0.45		XXX
70240	26	A	X-RAY EXAM PITUITARY SADDLE	0.20	0.09	0.01	0.30	2	XXX
70250		A	X-RAY EXAM OF SKULL	0.25	0.74	0.06	1.05	2	XXX
70250	TC	A	X-RAY EXAM OF SKULL	0.00	0.63	0.04	0.67		XXX
70250	26	A	X-RAY EXAM OF SKULL	0.25	0.11	0.02	0.38	2	XXX
70260		A	X-RAY EXAM OF SKULL	0.35	1.05	0.08	1.48	2	XXX
70260	TC	A	X-RAY EXAM OF SKULL	0.00	0.89	0.06	0.95		XXX
70260	26	A	X-RAY EXAM OF SKULL	0.35	0.16	0.02	0.53	2	XXX
70300		A	X-RAY EXAM OF TEETH	0.10	0.31	0.03	0.44	2	XXX
70300	TC	A	X-RAY EXAM OF TEETH	0.00	0.26	0.02	0.28		XXX
70300	26	A	X-RAY EXAM OF TEETH	0.10	0.05	0.01	0.16	2	XXX
70310		A	X-RAY EXAM OF TEETH	0.16	0.49	0.04	0.69	2	XXX
70310	TC	A	X-RAY EXAM OF TEETH	0.00	0.42	0.03	0.45		XXX
70310	26	A	X-RAY EXAM OF TEETH	0.16	0.07	0.01	0.24	2	XXX
70320		A	FULL MOUTH X-RAY OF TEETH	0.23	0.89	0.07	1.19	2	XXX
70320	TC	A	FULL MOUTH X-RAY OF TEETH	0.00	0.79	0.05	0.84		XXX
70320	26	A	FULL MOUTH X-RAY OF TEETH	0.23	0.10	0.02	0.35	2	XXX
70328		A	X-RAY EXAM OF JAW JOINT	0.19	0.59	0.04	0.82	2	XXX
70328	TC	A	X-RAY EXAM OF JAW JOINT	0.00	0.50	0.03	0.53		XXX
70328	26	A	X-RAY EXAM OF JAW JOINT	0.19	0.09	0.01	0.29	2	XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
70330		A	X-RAY EXAM OF JAW JOINTS	0.25	0.95	0.07	1.27	2	XXX
70330	TC	A	X-RAY EXAM OF JAW JOINTS	0.00	0.84	0.05	0.89		XXX
70330	26	A	X-RAY EXAM OF JAW JOINTS	0.25	0.11	0.02	0.38	2	XXX
70332		A	X-RAY EXAM OF JAW JOINT	0.58	2.37	0.17	3.12	2	XXX
70332	TC	A	X-RAY EXAM OF JAW JOINT	0.00	2.11	0.13	2.24		XXX
70332	26	A	X-RAY EXAM OF JAW JOINT	0.58	0.26	0.04	0.88	2	XXX
70333		D	X-RAY EXAM OF JAW JOINT	0.00	0.00	0.00	0.00		XXX
70336		A	MAGNETIC IMAGE JAW JOINT	1.00	11.70	0.77	13.47	2	XXX
70336	TC	A	MAGNETIC IMAGE JAW JOINT	0.00	11.25	0.71	11.96		XXX
70336	26	A	MAGNETIC IMAGE JAW JOINT	1.00	0.45	0.06	1.51	2	XXX
70350		A	X-RAY HEAD FOR ORTHODONTIA	0.17	0.45	0.03	0.65	2	XXX
70350	TC	A	X-RAY HEAD FOR ORTHODONTIA	0.00	0.37	0.02	0.39		XXX
70350	26	A	X-RAY HEAD FOR ORTHODONTIA	0.17	0.08	0.01	0.26	2	XXX
70355		A	PANORAMIC X-RAY OF JAWS	0.21	0.67	0.05	0.93	2	XXX
70355	TC	A	PANORAMIC X-RAY OF JAWS	0.00	0.58	0.04	0.62		XXX
70355	26	A	PANORAMIC X-RAY OF JAWS	0.21	0.09	0.01	0.31	2	XXX
70360		A	X-RAY EXAM OF NECK	0.18	0.50	0.04	0.72	2	XXX
70360	TC	A	X-RAY EXAM OF NECK	0.00	0.42	0.03	0.45		XXX
70360	26	A	X-RAY EXAM OF NECK	0.18	0.08	0.01	0.27	2	XXX
70370		A	THROAT X-RAY & FLUOROSCOPY	0.33	1.46	0.10	1.89	2	XXX
70370	TC	A	THROAT X-RAY & FLUOROSCOPY	0.00	1.31	0.08	1.39		XXX
70370	26	A	THROAT X-RAY & FLUOROSCOPY	0.33	0.15	0.02	0.50	2	XXX
70371		A	SPEECH EVALUATION, COMPLEX	0.88	2.51	0.19	3.58	2	XXX
70371	TC	A	SPEECH EVALUATION, COMPLEX	0.00	2.11	0.13	2.24		XXX
70371	26	A	SPEECH EVALUATION, COMPLEX	0.88	0.40	0.06	1.34	2	XXX
70373		A	CONTRAST X-RAY OF LARYNX	0.46	2.00	0.14	2.60	2	XXX
70373	TC	A	CONTRAST X-RAY OF LARYNX	0.00	1.79	0.11	1.90		XXX
70373	26	A	CONTRAST X-RAY OF LARYNX	0.46	0.21	0.03	0.70	2	XXX
70374		D	CONTRAST X-RAY OF LARYNX	0.00	0.00	0.00	0.00		XXX
70380		A	X-RAY EXAM OF SALIVARY GLAND	0.18	0.76	0.05	0.99	2	XXX
70380	TC	A	X-RAY EXAM OF SALIVARY GLAND	0.00	0.68	0.04	0.72		XXX
70380	26	A	X-RAY EXAM OF SALIVARY GLAND	0.18	0.08	0.01	0.27	2	XXX
70390		A	X-RAY EXAM OF SALIVARY DUCT	0.39	1.96	0.14	2.49	2	XXX
70390	TC	A	X-RAY EXAM OF SALIVARY DUCT	0.00	1.79	0.11	1.90		XXX
70390	26	A	X-RAY EXAM OF SALIVARY DUCT	0.39	0.17	0.03	0.59	2	XXX
70391		D	X-RAY EXAM OF SALIVARY DUCT	0.00	0.00	0.00	0.00		XXX
70450		A	CAT SCAN OF HEAD OR BRAIN	0.90	5.14	0.36	6.40	2	XXX
70450	TC	A	CAT SCAN OF HEAD OR BRAIN	0.00	4.74	0.30	5.04		XXX
70450	26	A	CAT SCAN OF HEAD OR BRAIN	0.90	0.40	0.06	1.36	2	XXX
70460		A	CONTRAST CAT SCAN OF HEAD	1.19	6.21	0.44	7.84	2	XXX
70460	TC	A	CONTRAST CAT SCAN OF HEAD	0.00	5.68	0.36	6.04		XXX
70460	26	A	CONTRAST CAT SCAN OF HEAD	1.19	0.53	0.08	1.80	2	XXX
70470		A	CONTRAST CAT SCANS OF HEAD	1.34	7.70	0.54	9.58	2	XXX
70470	TC	A	CONTRAST CAT SCANS OF HEAD	0.00	7.10	0.45	7.55		XXX
70470	26	A	CONTRAST CAT SCANS OF HEAD	1.34	0.60	0.09	2.03	2	XXX
70480		A	CAT SCAN OF SKULL	1.35	5.35	0.39	7.09	2	XXX
70480	TC	A	CAT SCAN OF SKULL	0.00	4.74	0.30	5.04		XXX
70480	26	A	CAT SCAN OF SKULL	1.35	0.61	0.09	2.05	2	XXX
70481		A	CONTRAST CAT SCAN OF SKULL	1.46	6.33	0.45	8.24	2	XXX
70481	TC	A	CONTRAST CAT SCAN OF SKULL	0.00	5.68	0.36	6.04		XXX
70481	26	A	CONTRAST CAT SCAN OF SKULL	1.46	0.65	0.09	2.20	2	XXX
70482		A	CONTRAST CAT SCANS OF SKULL	1.53	7.78	0.55	9.86	2	XXX
70482	TC	A	CONTRAST CAT SCANS OF SKULL	0.00	7.10	0.45	7.55		XXX
70482	26	A	CONTRAST CAT SCANS OF SKULL	1.53	0.68	0.10	2.31	2	XXX
70486		A	CAT SCAN OF FACE, JAW	1.20	5.28	0.38	6.86	2	XXX
70486	TC	A	CAT SCAN OF FACE, JAW	0.00	4.74	0.30	5.04		XXX
70486	26	A	CAT SCAN OF FACE, JAW	1.20	0.54	0.08	1.82	2	XXX
70487		A	CONTRAST CAT SCAN, FACE/JAW	1.37	6.29	0.45	8.11	2	XXX
70487	TC	A	CONTRAST CAT SCAN, FACE/JAW	0.00	5.68	0.36	6.04		XXX
70487	26	A	CONTRAST CAT SCAN, FACE/JAW	1.37	0.61	0.09	2.07	2	XXX
70488		A	CONTRAST CAT SCANS FACE/JAW	1.50	7.77	0.55	9.82	2	XXX
70488	TC	A	CONTRAST CAT SCANS FACE/JAW	0.00	7.10	0.45	7.55		XXX
70488	26	A	CONTRAST CAT SCANS FACE/JAW	1.50	0.67	0.10	2.27	2	XXX
70490		A	CAT SCAN OF NECK TISSUE	1.35	5.35	0.39	7.09	2	XXX
70490	TC	A	CAT SCAN OF NECK TISSUE	0.00	4.74	0.30	5.04		XXX
70490	26	A	CAT SCAN OF NECK TISSUE	1.35	0.61	0.09	2.05	2	XXX
70491		A	CONTRAST CAT OF NECK TISSUE	1.46	6.33	0.45	8.24	2	XXX
70491	TC	A	CONTRAST CAT OF NECK TISSUE	0.00	5.68	0.36	6.04		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
70491	26	A	CONTRAST CAT OF NECK TISSUE	1.46	0.65	0.09	2.20	2	XXX
70492		A	CONTRAST CAT OF NECK TISSUE	1.53	7.78	0.55	9.86	2	XXX
70492	TC	A	CONTRAST CAT OF NECK TISSUE	0.00	7.10	0.45	7.55		XXX
70492	26	A	CONTRAST CAT OF NECK TISSUE	1.53	0.68	0.10	2.31	2	XXX
70540		A	MAGNETIC IMAGE, FACE, NECK (MRI)	1.56	11.95	0.81	14.32	2	XXX
70540	TC	A	MAGNETIC IMAGE, FACE, NECK (MRI)	0.00	11.25	0.71	11.96		XXX
70540	26	A	MAGNETIC IMAGE, FACE, NECK (MRI)	1.56	0.70	0.10	2.36	2	XXX
70551		A	MAGNETIC IMAGE, BRAIN (MRI)	1.56	11.95	0.81	14.32	2	XXX
70551	TC	A	MAGNETIC IMAGE, BRAIN (MRI)	0.00	11.25	0.71	11.96		XXX
70551	26	A	MAGNETIC IMAGE, BRAIN (MRI)	1.56	0.70	0.10	2.36	2	XXX
70552		A	MAGNETIC IMAGE, BRAIN (MRI)	1.87	14.34	0.97	17.18	2	XXX
70552	TC	A	MAGNETIC IMAGE, BRAIN (MRI)	0.00	13.50	0.85	14.35		XXX
70552	26	A	MAGNETIC IMAGE, BRAIN (MRI)	1.87	0.84	0.12	2.83	2	XXX
70553		A	MAGNETIC IMAGE, BRAIN (MRI)	2.49	26.12	1.73	30.34	2	XXX
70553	TC	A	MAGNETIC IMAGE, BRAIN (MRI)	0.00	25.00	1.57	26.57		XXX
70553	26	A	MAGNETIC IMAGE, BRAIN (MRI)	2.49	1.12	0.16	3.77	2	XXX
71010		A	CHEST X-RAY	0.19	0.56	0.04	0.79	2	XXX
71010	TC	A	CHEST X-RAY	0.00	0.48	0.03	0.51		XXX
71010	26	A	CHEST X-RAY	0.19	0.08	0.01	0.28	2	XXX
71015		A	CHEST X-RAY	0.22	0.63	0.04	0.89	2	XXX
71015	TC	A	CHEST X-RAY	0.00	0.53	0.03	0.56		XXX
71015	26	A	CHEST X-RAY	0.22	0.10	0.01	0.33	2	XXX
71020		A	CHEST X-RAY	0.23	0.73	0.05	1.01	2	XXX
71020	TC	A	CHEST X-RAY	0.00	0.63	0.04	0.67		XXX
71020	26	A	CHEST X-RAY	0.23	0.10	0.01	0.34	2	XXX
71021		A	CHEST X-RAY	0.28	0.86	0.07	1.21	2	XXX
71021	TC	A	CHEST X-RAY	0.00	0.74	0.05	0.79		XXX
71021	26	A	CHEST X-RAY	0.28	0.12	0.02	0.42	2	XXX
71022		A	CHEST X-RAY	0.32	0.88	0.07	1.27	2	XXX
71022	TC	A	CHEST X-RAY	0.00	0.74	0.05	0.79		XXX
71022	26	A	CHEST X-RAY	0.32	0.14	0.02	0.48	2	XXX
71023		A	CHEST X-RAY AND FLUOROSCOPY	0.40	0.97	0.08	1.45	2	XXX
71023	TC	A	CHEST X-RAY AND FLUOROSCOPY	0.00	0.79	0.05	0.84		XXX
71023	26	A	CHEST X-RAY AND FLUOROSCOPY	0.40	0.18	0.03	0.61	2	XXX
71030		A	CHEST X-RAY	0.32	0.93	0.07	1.32	2	XXX
71030	TC	A	CHEST X-RAY	0.00	0.79	0.05	0.84		XXX
71030	26	A	CHEST X-RAY	0.32	0.14	0.02	0.48	2	XXX
71034		A	CHEST X-RAY & FLUOROSCOPY	0.49	1.67	0.12	2.28	2	XXX
71034	TC	A	CHEST X-RAY & FLUOROSCOPY	0.00	1.45	0.09	1.54		XXX
71034	26	A	CHEST X-RAY & FLUOROSCOPY	0.49	0.22	0.03	0.74	2	XXX
71035		A	CHEST X-RAY	0.19	0.61	0.04	0.84	2	XXX
71035	TC	A	CHEST X-RAY	0.00	0.53	0.03	0.56		XXX
71035	26	A	CHEST X-RAY	0.19	0.08	0.01	0.28	2	XXX
71036		A	X-RAY GUIDANCE FOR BIOPSY	0.58	1.84	0.14	2.56	2	XXX
71036	TC	A	X-RAY GUIDANCE FOR BIOPSY	0.00	1.58	0.10	1.68		XXX
71036	26	A	X-RAY GUIDANCE FOR BIOPSY	0.58	0.26	0.04	0.88	2	XXX
71037		D	X-RAY GUIDANCE FOR BIOPSY	0.00	0.00	0.00	0.00		XXX
71038		A	X-RAY GUIDANCE FOR BIOPSY	0.58	1.95	0.15	2.68	2	XXX
71038	TC	A	X-RAY GUIDANCE FOR BIOPSY	0.00	1.69	0.11	1.80		XXX
71038	26	A	X-RAY GUIDANCE FOR BIOPSY	0.58	0.26	0.04	0.88	2	XXX
71040		A	CONTRAST X-RAY OF BRONCHI	0.62	1.75	0.13	2.50	2	XXX
71040	TC	A	CONTRAST X-RAY OF BRONCHI	0.00	1.47	0.09	1.56		XXX
71040	26	A	CONTRAST X-RAY OF BRONCHI	0.62	0.28	0.04	0.94	2	XXX
71041		D	CONTRAST X-RAY OF BRONCHI	0.00	0.00	0.00	0.00		XXX
71060		A	CONTRAST X-RAY OF BRONCHI	0.78	2.56	0.19	3.53	2	XXX
71060	TC	A	CONTRAST X-RAY OF BRONCHI	0.00	2.21	0.14	2.35		XXX
71060	26	A	CONTRAST X-RAY OF BRONCHI	0.78	0.35	0.05	1.18	2	XXX
71061		D	CONTRAST X-RAY OF BRONCHI	0.00	0.00	0.00	0.00		XXX
71090		A	X-RAY & PACEMAKER INSERTION	0.58	1.95	0.15	2.68	2	XXX
71090	TC	A	X-RAY & PACEMAKER INSERTION	0.00	1.69	0.11	1.80		XXX
71090	26	A	X-RAY & PACEMAKER INSERTION	0.58	0.26	0.04	0.88	2	XXX
71100		A	X-RAY EXAM OF RIBS	0.23	0.68	0.06	0.97	2	XXX
71100	TC	A	X-RAY EXAM OF RIBS	0.00	0.58	0.04	0.62		XXX
71100	26	A	X-RAY EXAM OF RIBS	0.23	0.10	0.02	0.35	2	XXX
71101		A	X-RAY EXAM OF RIBS, CHEST	0.28	0.81	0.06	1.15	2	XXX
71101	TC	A	X-RAY EXAM OF RIBS, CHEST	0.00	0.68	0.04	0.72		XXX
71101	26	A	X-RAY EXAM OF RIBS, CHEST	0.28	0.13	0.02	0.43	2	XXX
71110		A	X-RAY EXAM OF RIBS	0.28	0.92	0.07	1.27	2	XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCP*CS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
71110	TC	A	X-RAY EXAM OF RIBS	0.00	0.79	0.05	0.84		XXX
71110	26	A	X-RAY EXAM OF RIBS	0.28	0.13	0.02	0.43	2	XXX
71111		A	X-RAY EXAM OF RIBS, CHEST	0.33	1.04	0.08	1.45	2	XXX
71111	TC	A	X-RAY EXAM OF RIBS, CHEST	0.00	0.89	0.06	0.95		XXX
71111	26	A	X-RAY EXAM OF RIBS, CHEST	0.33	0.15	0.02	0.50	2	XXX
71120		A	X-RAY EXAM OF BREASTBONE	0.21	0.75	0.05	1.01	2	XXX
71120	TC	A	X-RAY EXAM OF BREASTBONE	0.00	0.66	0.04	0.70		XXX
71120	26	A	X-RAY EXAM OF BREASTBONE	0.21	0.09	0.01	0.31	2	XXX
71130		A	X-RAY EXAM OF BREASTBONE	0.23	0.81	0.05	1.09	2	XXX
71130	TC	A	X-RAY EXAM OF BREASTBONE	0.00	0.71	0.04	0.75		XXX
71130	26	A	X-RAY EXAM OF BREASTBONE	0.23	0.10	0.01	0.34	2	XXX
71250		A	CAT SCAN OF CHEST	1.22	6.47	0.45	8.14	2	XXX
71250	TC	A	CAT SCAN OF CHEST	0.00	5.92	0.37	6.29		XXX
71250	26	A	CAT SCAN OF CHEST	1.22	0.55	0.08	1.85	2	XXX
71260		A	CONTRAST CAT SCAN OF CHEST	1.31	7.69	0.53	9.53	2	XXX
71260	TC	A	CONTRAST CAT SCAN OF CHEST	0.00	7.10	0.45	7.55		XXX
71260	26	A	CONTRAST CAT SCAN OF CHEST	1.31	0.59	0.08	1.98	2	XXX
71270		A	CONTRAST CAT SCANS OF CHEST	1.46	9.53	0.65	11.64	2	XXX
71270	TC	A	CONTRAST CAT SCANS OF CHEST	0.00	8.88	0.56	9.44		XXX
71270	26	A	CONTRAST CAT SCANS OF CHEST	1.46	0.65	0.09	2.20	2	XXX
71550		A	MAGNETIC IMAGE, CHEST	1.69	12.01	0.82	14.52	2	XXX
71550	TC	A	MAGNETIC IMAGE, CHEST	0.00	11.25	0.71	11.96		XXX
71550	26	A	MAGNETIC IMAGE, CHEST	1.69	0.76	0.11	2.56	2	XXX
72010		A	X-RAY EXAM OF SPINE	0.47	1.24	0.09	1.80	2	XXX
72010	TC	A	X-RAY EXAM OF SPINE	0.00	1.03	0.06	1.09		XXX
72010	26	A	X-RAY EXAM OF SPINE	0.47	0.21	0.03	0.71	2	XXX
72020		A	X-RAY EXAM OF SPINE	0.15	0.49	0.04	0.68	2	XXX
72020	TC	A	X-RAY EXAM OF SPINE	0.00	0.42	0.03	0.45		XXX
72020	26	A	X-RAY EXAM OF SPINE	0.15	0.07	0.01	0.23	2	XXX
72040		A	X-RAY EXAM OF NECK SPINE	0.23	0.71	0.05	0.99	2	XXX
72040	TC	A	X-RAY EXAM OF NECK SPINE	0.00	0.61	0.04	0.65		XXX
72040	26	A	X-RAY EXAM OF NECK SPINE	0.23	0.10	0.01	0.34	2	XXX
72050		A	X-RAY EXAM OF NECK SPINE	0.32	1.03	0.08	1.43	2	XXX
72050	TC	A	X-RAY EXAM OF NECK SPINE	0.00	0.89	0.06	0.95		XXX
72050	26	A	X-RAY EXAM OF NECK SPINE	0.32	0.14	0.02	0.48	2	XXX
72052		A	X-RAY EXAM OF NECK SPINE	0.37	1.30	0.09	1.76	2	XXX
72052	TC	A	X-RAY EXAM OF NECK SPINE	0.00	1.13	0.07	1.20		XXX
72052	26	A	X-RAY EXAM OF NECK SPINE	0.37	0.17	0.02	0.56	2	XXX
72069		A	X-RAY EXAM OF TRUNK SPINE	0.23	0.60	0.04	0.87	2	XXX
72069	TC	A	X-RAY EXAM OF TRUNK SPINE	0.00	0.50	0.03	0.53		XXX
72069	26	A	X-RAY EXAM OF TRUNK SPINE	0.23	0.10	0.01	0.34	2	XXX
72070		A	X-RAY EXAM OF THORAX SPINE	0.23	0.76	0.05	1.04	2	XXX
72070	TC	A	X-RAY EXAM OF THORAX SPINE	0.00	0.66	0.04	0.70		XXX
72070	26	A	X-RAY EXAM OF THORAX SPINE	0.23	0.10	0.01	0.34	2	XXX
72072		A	X-RAY EXAM OF THORACIC SPINE	0.23	0.84	0.06	1.13	2	XXX
72072	TC	A	X-RAY EXAM OF THORACIC SPINE	0.00	0.74	0.05	0.79		XXX
72072	26	A	X-RAY EXAM OF THORACIC SPINE	0.23	0.10	0.01	0.34	2	XXX
72074		A	X-RAY EXAM OF THORACIC SPINE	0.23	1.02	0.07	1.32	2	XXX
72074	TC	A	X-RAY EXAM OF THORACIC SPINE	0.00	0.92	0.06	0.98		XXX
72074	26	A	X-RAY EXAM OF THORACIC SPINE	0.23	0.10	0.01	0.34	2	XXX
72080		A	X-RAY EXAM OF TRUNK SPINE	0.23	0.78	0.05	1.06	2	XXX
72080	TC	A	X-RAY EXAM OF TRUNK SPINE	0.00	0.68	0.04	0.72		XXX
72080	26	A	X-RAY EXAM OF TRUNK SPINE	0.23	0.10	0.01	0.34	2	XXX
72090		A	X-RAY EXAM OF TRUNK SPINE	0.29	0.81	0.06	1.16	2	XXX
72090	TC	A	X-RAY EXAM OF TRUNK SPINE	0.00	0.68	0.04	0.72		XXX
72090	26	A	X-RAY EXAM OF TRUNK SPINE	0.29	0.13	0.02	0.44	2	XXX
72100		A	X-RAY EXAM OF LOWER SPINE	0.23	0.78	0.05	1.06	2	XXX
72100	TC	A	X-RAY EXAM OF LOWER SPINE	0.00	0.68	0.04	0.72		XXX
72100	26	A	X-RAY EXAM OF LOWER SPINE	0.23	0.10	0.01	0.34	2	XXX
72110		A	X-RAY EXAM OF LOWER SPINE	0.32	1.06	0.08	1.46	2	XXX
72110	TC	A	X-RAY EXAM OF LOWER SPINE	0.00	0.92	0.06	0.98		XXX
72110	26	A	X-RAY EXAM OF LOWER SPINE	0.32	0.14	0.02	0.48	2	XXX
72114		A	X-RAY EXAM OF LOWER SPINE	0.37	1.35	0.09	1.81	2	XXX
72114	TC	A	X-RAY EXAM OF LOWER SPINE	0.00	1.18	0.07	1.25		XXX
72114	26	A	X-RAY EXAM OF LOWER SPINE	0.37	0.17	0.02	0.56	2	XXX
72120		A	X-RAY EXAM OF LOWER SPINE	0.23	0.99	0.07	1.29	2	XXX
72120	TC	A	X-RAY EXAM OF LOWER SPINE	0.00	0.89	0.06	0.95		XXX
72120	26	A	X-RAY EXAM OF LOWER SPINE	0.23	0.10	0.01	0.34	2	XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
72125		A	CAT SCAN OF NECK SPINE	1.22	6.47	0.45	8.14	2	XXX
72125	TC	A	CAT SCAN OF NECK SPINE	0.00	5.92	0.37	6.29		XXX
72125	26	A	CAT SCAN OF NECK SPINE	1.22	0.55	0.08	1.85	2	XXX
72126		A	CONTRAST CAT SCAN OF NECK	1.29	7.67	0.53	9.49	2	XXX
72126	TC	A	CONTRAST CAT SCAN OF NECK	0.00	7.10	0.45	7.55		XXX
72126	26	A	CONTRAST CAT SCAN OF NECK	1.29	0.57	0.08	1.94	2	XXX
72127		A	CONTRAST CAT SCANS OF NECK	1.34	9.48	0.65	11.47	2	XXX
72127	TC	A	CONTRAST CAT SCANS OF NECK	0.00	8.88	0.56	9.44		XXX
72127	26	A	CONTRAST CAT SCANS OF NECK	1.34	0.60	0.09	2.03	2	XXX
72128		A	CAT SCAN OF THORAX SPINE	1.22	6.47	0.45	8.14	2	XXX
72128	TC	A	CAT SCAN OF THORAX SPINE	0.00	5.92	0.37	6.29		XXX
72128	26	A	CAT SCAN OF THORAX SPINE	1.22	0.55	0.08	1.85	2	XXX
72129		A	CONTRAST CAT SCAN OF THORAX	1.29	7.67	0.53	9.49	2	XXX
72129	TC	A	CONTRAST CAT SCAN OF THORAX	0.00	7.10	0.45	7.55		XXX
72129	26	A	CONTRAST CAT SCAN OF THORAX	1.29	0.57	0.08	1.94	2	XXX
72130		A	CONTRAST CAT SCANS OF THORAX	1.34	9.48	0.65	11.47	2	XXX
72130	TC	A	CONTRAST CAT SCANS OF THORAX	0.00	8.88	0.56	9.44		XXX
72130	26	A	CONTRAST CAT SCANS OF THORAX	1.34	0.60	0.09	2.03	2	XXX
72131		A	CAT SCAN OF LOWER SPINE	1.22	6.47	0.45	8.14	2	XXX
72131	TC	A	CAT SCAN OF LOWER SPINE	0.00	5.92	0.37	6.29		XXX
72131	26	A	CAT SCAN OF LOWER SPINE	1.22	0.55	0.08	1.85	2	XXX
72132		A	CONTRAST CAT OF LOWER SPINE	1.29	7.67	0.53	9.49	2	XXX
72132	TC	A	CONTRAST CAT OF LOWER SPINE	0.00	7.10	0.45	7.55		XXX
72132	26	A	CONTRAST CAT OF LOWER SPINE	1.29	0.57	0.08	1.94	2	XXX
72133		A	CONTRAST CAT SCANS, LOW SPINE	1.34	9.48	0.65	11.47	2	XXX
72133	TC	A	CONTRAST CAT SCANS, LOW SPINE	0.00	8.88	0.56	9.44		XXX
72133	26	A	CONTRAST CAT SCANS, LOW SPINE	1.34	0.60	0.09	2.03	2	XXX
72141		A	MAGNETIC IMAGE, NECK SPINE	1.69	12.01	0.82	14.52	2	XXX
72141	TC	A	MAGNETIC IMAGE, NECK SPINE	0.00	11.25	0.71	11.96		XXX
72141	26	A	MAGNETIC IMAGE, NECK SPINE	1.69	0.76	0.11	2.56	2	XXX
72142		A	MAGNETIC IMAGE, NECK SPINE	2.03	14.41	0.98	17.42	2	XXX
72142	TC	A	MAGNETIC IMAGE, NECK SPINE	0.00	13.50	0.85	14.35		XXX
72142	26	A	MAGNETIC IMAGE, NECK SPINE	2.03	0.91	0.13	3.07	2	XXX
72146		A	MAGNETIC IMAGE, CHEST SPINE	1.69	13.26	0.89	15.84	2	XXX
72146	TC	A	MAGNETIC IMAGE, CHEST SPINE	0.00	12.50	0.78	13.28		XXX
72146	26	A	MAGNETIC IMAGE, CHEST SPINE	1.69	0.76	0.11	2.56	2	XXX
72147		A	MAGNETIC IMAGE, CHEST SPINE	2.03	14.41	0.98	17.42	2	XXX
72147	TC	A	MAGNETIC IMAGE, CHEST SPINE	0.00	13.50	0.85	14.35		XXX
72147	26	A	MAGNETIC IMAGE, CHEST SPINE	2.03	0.91	0.13	3.07	2	XXX
72148		A	MAGNETIC IMAGE, LUMBAR SPINE	1.56	13.20	0.88	15.64	2	XXX
72148	TC	A	MAGNETIC IMAGE, LUMBAR SPINE	0.00	12.50	0.78	13.28		XXX
72148	26	A	MAGNETIC IMAGE, LUMBAR SPINE	1.56	0.70	0.10	2.36	2	XXX
72149		A	MAGNETIC IMAGE, LUMBAR SPINE	1.87	14.34	0.97	17.18	2	XXX
72149	TC	A	MAGNETIC IMAGE, LUMBAR SPINE	0.00	13.50	0.85	14.35		XXX
72149	26	A	MAGNETIC IMAGE, LUMBAR SPINE	1.87	0.84	0.12	2.83	2	XXX
72156		A	MAGNETIC IMAGE, SPINE (MRI)	2.71	26.21	1.74	30.66	2	XXX
72156	TC	A	MAGNETIC IMAGE, SPINE (MRI)	0.00	25.00	1.57	26.57		XXX
72156	26	A	MAGNETIC IMAGE, SPINE (MRI)	2.71	1.21	0.17	4.09	2	XXX
72157		A	MAGNETIC IMAGE, SPINE (MRI)	2.71	26.21	1.74	30.66	2	XXX
72157	TC	A	MAGNETIC IMAGE, SPINE (MRI)	0.00	25.00	1.57	26.57		XXX
72157	26	A	MAGNETIC IMAGE, SPINE (MRI)	2.71	1.21	0.17	4.09	2	XXX
72158		A	MAGNETIC IMAGE, SPINE (MRI)	2.49	26.12	1.73	30.34	2	XXX
72158	TC	A	MAGNETIC IMAGE, SPINE (MRI)	0.00	25.00	1.57	26.57		XXX
72158	26	A	MAGNETIC IMAGE, SPINE (MRI)	2.49	1.12	0.16	3.77	2	XXX
72170		A	X-RAY EXAM OF PELVIS	0.17	0.60	0.04	0.81	2	XXX
72170	TC	A	X-RAY EXAM OF PELVIS	0.00	0.53	0.03	0.56		XXX
72170	26	A	X-RAY EXAM OF PELVIS	0.17	0.07	0.01	0.25	2	XXX
72190		A	X-RAY EXAM OF PELVIS	0.22	0.78	0.05	1.05	2	XXX
72190	TC	A	X-RAY EXAM OF PELVIS	0.00	0.68	0.04	0.72		XXX
72190	26	A	X-RAY EXAM OF PELVIS	0.22	0.10	0.01	0.33	2	XXX
72192		A	CAT SCAN OF PELVIS	1.14	6.43	0.44	8.01	2	XXX
72192	TC	A	CAT SCAN OF PELVIS	0.00	5.92	0.37	6.29		XXX
72192	26	A	CAT SCAN OF PELVIS	1.14	0.51	0.07	1.72	2	XXX
72193		A	CONTRAST CAT SCAN OF PELVIS	1.22	7.42	0.51	9.15	2	XXX
72193	TC	A	CONTRAST CAT SCAN OF PELVIS	0.00	6.87	0.43	7.30		XXX
72193	26	A	CONTRAST CAT SCAN OF PELVIS	1.22	0.55	0.08	1.85	2	XXX
72194		A	CONTRAST CAT SCANS OF PELVIS	1.29	9.10	0.61	11.00	2	XXX
72194	TC	A	CONTRAST CAT SCANS OF PELVIS	0.00	8.53	0.53	9.06		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPs*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
72194	26	A	CONTRAST CAT SCANS OF PELVIS	1.29	0.57	0.08	1.94	2	XXX
72196		A	MAGNETIC IMAGE, PELVIS	1.69	12.01	0.82	14.52	2	XXX
72196	TC	A	MAGNETIC IMAGE, PELVIS	0.00	11.25	0.71	11.96		XXX
72196	26	A	MAGNETIC IMAGE, PELVIS	1.69	0.76	0.11	2.56	2	XXX
72200		A	X-RAY EXAM SACROILIAC JOINTS	0.18	0.61	0.04	0.83	2	XXX
72200	TC	A	X-RAY EXAM SACROILIAC JOINTS	0.00	0.53	0.03	0.56		XXX
72200	26	A	X-RAY EXAM SACROILIAC JOINTS	0.18	0.08	0.01	0.27	2	XXX
72202		A	X-RAY EXAM SACROILIAC JOINTS	0.20	0.72	0.05	0.97	2	XXX
72202	TC	A	X-RAY EXAM SACROILIAC JOINTS	0.00	0.63	0.04	0.67		XXX
72202	26	A	X-RAY EXAM SACROILIAC JOINTS	0.20	0.09	0.01	0.30	2	XXX
72220		A	X-RAY EXAM OF TAILBONE	0.18	0.66	0.05	0.89	2	XXX
72220	TC	A	X-RAY EXAM OF TAILBONE	0.00	0.58	0.04	0.62		XXX
72220	26	A	X-RAY EXAM OF TAILBONE	0.18	0.08	0.01	0.27	2	XXX
72240		A	CONTRAST X-RAY OF NECK SPINE	0.96	5.19	0.36	6.51	2	XXX
72240	TC	A	CONTRAST X-RAY OF NECK SPINE	0.00	4.76	0.30	5.06		XXX
72240	26	A	CONTRAST X-RAY OF NECK SPINE	0.96	0.43	0.06	1.45	2	XXX
72241		D	CONTRAST X-RAY OF NECK SPINE	0.00	0.00	0.00	0.00		XXX
72255		A	CONTRAST X-RAY THORAX SPINE	0.96	4.78	0.33	6.07	2	XXX
72255	TC	A	CONTRAST X-RAY THORAX SPINE	0.00	4.35	0.27	4.62		XXX
72255	26	A	CONTRAST X-RAY THORAX SPINE	0.96	0.43	0.06	1.45	2	XXX
72256		D	CONTRAST X-RAY THORAX SPINE	0.00	0.00	0.00	0.00		XXX
72265		A	CONTRAST X-RAY LOWER SPINE	0.87	4.47	0.32	5.66	2	XXX
72265	TC	A	CONTRAST X-RAY LOWER SPINE	0.00	4.08	0.26	4.34		XXX
72265	26	A	CONTRAST X-RAY LOWER SPINE	0.87	0.39	0.06	1.32	2	XXX
72266		D	CONTRAST X-RAY LOWER SPINE	0.00	0.00	0.00	0.00		XXX
72270		A	CONTRAST X-RAY OF SPINE	1.40	6.75	0.47	8.62	2	XXX
72270	TC	A	CONTRAST X-RAY OF SPINE	0.00	6.12	0.38	6.50		XXX
72270	26	A	CONTRAST X-RAY OF SPINE	1.40	0.63	0.09	2.12	2	XXX
72271		D	CONTRAST X-RAY OF SPINE	0.00	0.00	0.00	0.00		XXX
72285		A	X-RAY OF NECK SPINE DISK	0.87	8.81	0.59	10.27	2	XXX
72285	TC	A	X-RAY OF NECK SPINE DISK	0.00	8.42	0.53	8.95		XXX
72285	26	A	X-RAY OF NECK SPINE DISK	0.87	0.39	0.06	1.32	2	XXX
72286		D	X-RAY OF NECK SPINE DISK	0.00	0.00	0.00	0.00		XXX
72295		A	X-RAY OF LOWER SPINE DISK	0.87	8.28	0.55	9.70	2	XXX
72295	TC	A	X-RAY OF LOWER SPINE DISK	0.00	7.89	0.49	8.38		XXX
72295	26	A	X-RAY OF LOWER SPINE DISK	0.87	0.39	0.06	1.32	2	XXX
72296		D	X-RAY OF LOWER SPINE DISK	0.00	0.00	0.00	0.00		XXX
73000		A	X-RAY EXAM OF COLLARBONE	0.16	0.60	0.04	0.80	2	XXX
73000	TC	A	X-RAY EXAM OF COLLARBONE	0.00	0.53	0.03	0.56		XXX
73000	26	A	X-RAY EXAM OF COLLARBONE	0.16	0.07	0.01	0.24	2	XXX
73010		A	X-RAY EXAM OF SHOULDER BLADE	0.18	0.61	0.04	0.83	2	XXX
73010	TC	A	X-RAY EXAM OF SHOULDER BLADE	0.00	0.53	0.03	0.56		XXX
73010	26	A	X-RAY EXAM OF SHOULDER BLADE	0.18	0.08	0.01	0.27	2	XXX
73020		A	X-RAY EXAM OF SHOULDER	0.15	0.55	0.04	0.74	2	XXX
73020	TC	A	X-RAY EXAM OF SHOULDER	0.00	0.48	0.03	0.51		XXX
73020	26	A	X-RAY EXAM OF SHOULDER	0.15	0.07	0.01	0.23	2	XXX
73030		A	X-RAY EXAM OF SHOULDER	0.19	0.66	0.05	0.90	2	XXX
73030	TC	A	X-RAY EXAM OF SHOULDER	0.00	0.58	0.04	0.62		XXX
73030	26	A	X-RAY EXAM OF SHOULDER	0.19	0.08	0.01	0.28	2	XXX
73040		A	CONTRAST X-RAY OF SHOULDER	0.58	2.37	0.17	3.12	2	XXX
73040	TC	A	CONTRAST X-RAY OF SHOULDER	0.00	2.11	0.13	2.24		XXX
73040	26	A	CONTRAST X-RAY OF SHOULDER	0.58	0.26	0.04	0.88	2	XXX
73041		D	CONTRAST X-RAY OF SHOULDER	0.00	0.00	0.00	0.00		XXX
73050		A	X-RAY EXAM OF SHOULDERS	0.21	0.77	0.05	1.03	2	XXX
73050	TC	A	X-RAY EXAM OF SHOULDERS	0.00	0.68	0.04	0.72		XXX
73050	26	A	X-RAY EXAM OF SHOULDERS	0.21	0.09	0.01	0.31	2	XXX
73060		A	X-RAY EXAM OF HUMERUS	0.17	0.66	0.05	0.88	2	XXX
73060	TC	A	X-RAY EXAM OF HUMERUS	0.00	0.58	0.04	0.62		XXX
73060	26	A	X-RAY EXAM OF HUMERUS	0.17	0.08	0.01	0.26	2	XXX
73070		A	X-RAY EXAM OF ELBOW	0.15	0.60	0.04	0.79	2	XXX
73070	TC	A	X-RAY EXAM OF ELBOW	0.00	0.53	0.03	0.56		XXX
73070	26	A	X-RAY EXAM OF ELBOW	0.15	0.07	0.01	0.23	2	XXX
73080		A	X-RAY EXAM OF ELBOW	0.18	0.66	0.05	0.89	2	XXX
73080	TC	A	X-RAY EXAM OF ELBOW	0.00	0.58	0.04	0.62		XXX
73080	26	A	X-RAY EXAM OF ELBOW	0.18	0.08	0.01	0.27	2	XXX
73085		A	CONTRAST X-RAY OF ELBOW	0.58	2.37	0.17	3.12	2	XXX
73085	TC	A	CONTRAST X-RAY OF ELBOW	0.00	2.11	0.13	2.24		XXX
73085	26	A	CONTRAST X-RAY OF ELBOW	0.58	0.26	0.04	0.88	2	XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
73086		D	CONTRAST X-RAY OF ELBOW	0.00	0.00	0.00	0.00		XXX
73090		A	X-RAY EXAM OF FOREARM	0.16	0.60	0.04	0.80	2	XXX
73090	TC	A	X-RAY EXAM OF FOREARM	0.00	0.53	0.03	0.56		XXX
73090	26	A	X-RAY EXAM OF FOREARM	0.16	0.07	0.01	0.24	2	XXX
73092		A	X-RAY EXAM OF ARM, INFANT	0.16	0.57	0.04	0.77	2	XXX
73092	TC	A	X-RAY EXAM OF ARM, INFANT	0.00	0.50	0.03	0.53		XXX
73092	26	A	X-RAY EXAM OF ARM, INFANT	0.16	0.07	0.01	0.24	2	XXX
73100		A	X-RAY EXAM OF WRIST	0.16	0.57	0.04	0.77	2	XXX
73100	TC	A	X-RAY EXAM OF WRIST	0.00	0.50	0.03	0.53		XXX
73100	26	A	X-RAY EXAM OF WRIST	0.16	0.07	0.01	0.24	2	XXX
73110		A	X-RAY EXAM OF WRIST	0.18	0.63	0.04	0.85	2	XXX
73110	TC	A	X-RAY EXAM OF WRIST	0.00	0.55	0.03	0.58		XXX
73110	26	A	X-RAY EXAM OF WRIST	0.18	0.08	0.01	0.27	2	XXX
73115		A	CONTRAST X-RAY OF WRIST	0.58	1.84	0.14	2.56	2	XXX
73115	TC	A	CONTRAST X-RAY OF WRIST	0.00	1.58	0.10	1.68		XXX
73115	26	A	CONTRAST X-RAY OF WRIST	0.58	0.26	0.04	0.88	2	XXX
73116		D	CONTRAST X-RAY OF WRIST	0.00	0.00	0.00	0.00		XXX
73120		A	X-RAY EXAM OF HAND	0.16	0.57	0.04	0.77	2	XXX
73120	TC	A	X-RAY EXAM OF HAND	0.00	0.50	0.03	0.53		XXX
73120	26	A	X-RAY EXAM OF HAND	0.16	0.07	0.01	0.24	2	XXX
73130		A	X-RAY EXAM OF HAND	0.18	0.63	0.04	0.85	2	XXX
73130	TC	A	X-RAY EXAM OF HAND	0.00	0.55	0.03	0.58		XXX
73130	26	A	X-RAY EXAM OF HAND	0.18	0.08	0.01	0.27	2	XXX
73140		A	X-RAY EXAM OF FINGER(S)	0.13	0.48	0.04	0.65	2	XXX
73140	TC	A	X-RAY EXAM OF FINGER(S)	0.00	0.42	0.03	0.45		XXX
73140	26	A	X-RAY EXAM OF FINGER(S)	0.13	0.06	0.01	0.20	2	XXX
73200		A	CAT SCAN OF ARM	1.14	5.49	0.38	7.01	2	XXX
73200	TC	A	CAT SCAN OF ARM	0.00	4.98	0.31	5.29		XXX
73200	26	A	CAT SCAN OF ARM	1.14	0.51	0.07	1.72	2	XXX
73201		A	CONTRAST CAT SCAN OF ARM	1.22	6.47	0.45	8.14	2	XXX
73201	TC	A	CONTRAST CAT SCAN OF ARM	0.00	5.92	0.37	6.29		XXX
73201	26	A	CONTRAST CAT SCAN OF ARM	1.22	0.55	0.08	1.85	2	XXX
73202		A	CONTRAST CAT SCANS OF ARM	1.29	8.03	0.55	9.87	2	XXX
73202	TC	A	CONTRAST CAT SCANS OF ARM	0.00	7.46	0.47	7.93		XXX
73202	26	A	CONTRAST CAT SCANS OF ARM	1.29	0.57	0.08	1.94	2	XXX
73220		A	MAGNETIC IMAGE, ARM, HAND	1.56	11.95	0.81	14.32	2	XXX
73220	TC	A	MAGNETIC IMAGE, ARM, HAND	0.00	11.25	0.71	11.96		XXX
73220	26	A	MAGNETIC IMAGE, ARM, HAND	1.56	0.70	0.10	2.36	2	XXX
73221		A	MAGNETIC IMAGE, JOINT OF ARM	1.00	11.70	0.77	13.47	2	XXX
73221	TC	A	MAGNETIC IMAGE, JOINT OF ARM	0.00	11.25	0.71	11.96		XXX
73221	26	A	MAGNETIC IMAGE, JOINT OF ARM	1.00	0.45	0.06	1.51	2	XXX
73500		A	X-RAY EXAM OF HIP	0.17	0.56	0.04	0.77	2	XXX
73500	TC	A	X-RAY EXAM OF HIP	0.00	0.48	0.03	0.51		XXX
73500	26	A	X-RAY EXAM OF HIP	0.17	0.08	0.01	0.26	2	XXX
73510		A	X-RAY EXAM OF HIP	0.22	0.68	0.05	0.95	2	XXX
73510	TC	A	X-RAY EXAM OF HIP	0.00	0.58	0.04	0.62		XXX
73510	26	A	X-RAY EXAM OF HIP	0.22	0.10	0.01	0.33	2	XXX
73520		A	X-RAY EXAM OF HIPS	0.27	0.80	0.06	1.13	2	XXX
73520	TC	A	X-RAY EXAM OF HIPS	0.00	0.68	0.04	0.72		XXX
73520	26	A	X-RAY EXAM OF HIPS	0.27	0.12	0.02	0.41	2	XXX
73525		A	CONTRAST X-RAY OF HIP	0.58	2.37	0.17	3.12	2	XXX
73525	TC	A	CONTRAST X-RAY OF HIP	0.00	2.11	0.13	2.24		XXX
73525	26	A	CONTRAST X-RAY OF HIP	0.58	0.26	0.04	0.88	2	XXX
73526		D	CONTRAST X-RAY OF HIP	0.00	0.00	0.00	0.00		XXX
73530		A	X-RAY EXAM OF HIP	0.30	0.66	0.05	1.01	2	XXX
73530	TC	A	X-RAY EXAM OF HIP	0.00	0.53	0.03	0.56		XXX
73530	26	A	X-RAY EXAM OF HIP	0.30	0.13	0.02	0.45	2	XXX
73540		A	X-RAY EXAM OF PELVIS & HIPS	0.21	0.68	0.05	0.94	2	XXX
73540	TC	A	X-RAY EXAM OF PELVIS & HIPS	0.00	0.58	0.04	0.62		XXX
73540	26	A	X-RAY EXAM OF PELVIS & HIPS	0.21	0.10	0.01	0.32	2	XXX
73550		A	X-RAY EXAM OF THIGH	0.18	0.66	0.05	0.89	2	XXX
73550	TC	A	X-RAY EXAM OF THIGH	0.00	0.58	0.04	0.62		XXX
73550	26	A	X-RAY EXAM OF THIGH	0.18	0.08	0.01	0.27	2	XXX
73560		A	X-RAY EXAM OF KNEE	0.17	0.60	0.04	0.81	2	XXX
73560	TC	A	X-RAY EXAM OF KNEE	0.00	0.53	0.03	0.56		XXX
73560	26	A	X-RAY EXAM OF KNEE	0.17	0.07	0.01	0.25	2	XXX
73562		A	X-RAY EXAM OF KNEE	0.19	0.67	0.05	0.91	2	XXX
73562	TC	A	X-RAY EXAM OF KNEE	0.00	0.58	0.04	0.62		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
73562	26	A	X-RAY EXAM OF KNEE	0.19	0.09	0.01	0.29	2	XXX
73564		A	X-RAY EXAM OF KNEE	0.23	0.73	0.06	1.02	2	XXX
73564	TC	A	X-RAY EXAM OF KNEE	0.00	0.63	0.04	0.67		XXX
73564	26	A	X-RAY EXAM OF KNEE	0.23	0.10	0.02	0.35	2	XXX
73565		A	X-RAY EXAM OF KNEE	0.17	0.57	0.04	0.78	2	XXX
73565	TC	A	X-RAY EXAM OF KNEE	0.00	0.50	0.03	0.53		XXX
73565	26	A	X-RAY EXAM OF KNEE	0.17	0.07	0.01	0.25	2	XXX
73580		A	CONTRAST X-RAY OF KNEE JOINT	0.58	2.89	0.21	3.68	2	XXX
73580	TC	A	CONTRAST X-RAY OF KNEE JOINT	0.00	2.63	0.17	2.80		XXX
73580	26	A	CONTRAST X-RAY OF KNEE JOINT	0.58	0.26	0.04	0.88	2	XXX
73581		D	CONTRAST X-RAY OF KNEE JOINT	0.00	0.00	0.00	0.00		XXX
73590		A	X-RAY EXAM OF LOWER LEG	0.17	0.60	0.04	0.81	2	XXX
73590	TC	A	X-RAY EXAM OF LOWER LEG	0.00	0.53	0.03	0.56		XXX
73590	26	A	X-RAY EXAM OF LOWER LEG	0.17	0.07	0.01	0.25	2	XXX
73592		A	X-RAY EXAM OF LEG, INFANT	0.16	0.57	0.04	0.77	2	XXX
73592	TC	A	X-RAY EXAM OF LEG, INFANT	0.00	0.50	0.03	0.53		XXX
73592	26	A	X-RAY EXAM OF LEG, INFANT	0.16	0.07	0.01	0.24	2	XXX
73600		A	X-RAY EXAM OF ANKLE	0.16	0.57	0.04	0.77	2	XXX
73600	TC	A	X-RAY EXAM OF ANKLE	0.00	0.50	0.03	0.53		XXX
73600	26	A	X-RAY EXAM OF ANKLE	0.16	0.07	0.01	0.24	2	XXX
73610		A	X-RAY EXAM OF ANKLE	0.18	0.63	0.04	0.85	2	XXX
73610	TC	A	X-RAY EXAM OF ANKLE	0.00	0.55	0.03	0.58		XXX
73610	26	A	X-RAY EXAM OF ANKLE	0.18	0.08	0.01	0.27	2	XXX
73615		A	CONTRAST X-RAY OF ANKLE	0.58	2.37	0.17	3.12	2	XXX
73615	TC	A	CONTRAST X-RAY OF ANKLE	0.00	2.11	0.13	2.24		XXX
73615	26	A	CONTRAST X-RAY OF ANKLE	0.58	0.26	0.04	0.88	2	XXX
73616		D	CONTRAST X-RAY OF ANKLE	0.00	0.00	0.00	0.00		XXX
73620		A	X-RAY EXAM OF FOOT	0.16	0.57	0.04	0.77	2	XXX
73620	TC	A	X-RAY EXAM OF FOOT	0.00	0.50	0.03	0.53		XXX
73620	26	A	X-RAY EXAM OF FOOT	0.16	0.07	0.01	0.24	2	XXX
73630		A	X-RAY EXAM OF FOOT	0.18	0.63	0.04	0.85	2	XXX
73630	TC	A	X-RAY EXAM OF FOOT	0.00	0.55	0.03	0.58		XXX
73630	26	A	X-RAY EXAM OF FOOT	0.18	0.08	0.01	0.27	2	XXX
73650		A	X-RAY EXAM OF HEEL	0.16	0.55	0.04	0.75	2	XXX
73650	TC	A	X-RAY EXAM OF HEEL	0.00	0.48	0.03	0.51		XXX
73650	26	A	X-RAY EXAM OF HEEL	0.16	0.07	0.01	0.24	2	XXX
73660		A	X-RAY EXAM OF TOE(S)	0.13	0.48	0.04	0.65	2	XXX
73660	TC	A	X-RAY EXAM OF TOE(S)	0.00	0.42	0.03	0.45		XXX
73660	26	A	X-RAY EXAM OF TOE(S)	0.13	0.06	0.01	0.20	2	XXX
73700		A	CAT SCAN OF LEG	1.14	5.49	0.38	7.01	2	XXX
73700	TC	A	CAT SCAN OF LEG	0.00	4.98	0.31	5.29		XXX
73700	26	A	CAT SCAN OF LEG	1.14	0.51	0.07	1.72	2	XXX
73701		A	CONTRAST CAT SCAN OF LEG	1.22	6.47	0.45	8.14	2	XXX
73701	TC	A	CONTRAST CAT SCAN OF LEG	0.00	5.92	0.37	6.29		XXX
73701	26	A	CONTRAST CAT SCAN OF LEG	1.22	0.55	0.08	1.85	2	XXX
73702		A	CONTRAST CAT SCANS OF LEG	1.29	8.03	0.55	9.87	2	XXX
73702	TC	A	CONTRAST CAT SCANS OF LEG	0.00	7.46	0.47	7.93		XXX
73702	26	A	CONTRAST CAT SCANS OF LEG	1.29	0.57	0.08	1.94	2	XXX
73720		A	MAGNETIC IMAGE, LEG, FOOT	1.56	11.95	0.81	14.32	2	XXX
73720	TC	A	MAGNETIC IMAGE, LEG, FOOT	0.00	11.25	0.71	11.96		XXX
73720	26	A	MAGNETIC IMAGE, LEG, FOOT	1.56	0.70	0.10	2.36	2	XXX
73721		A	MAGNETIC IMAGE, JOINT OF LEG	1.00	11.70	0.77	13.47	2	XXX
73721	TC	A	MAGNETIC IMAGE, JOINT OF LEG	0.00	11.25	0.71	11.96		XXX
73721	26	A	MAGNETIC IMAGE, JOINT OF LEG	1.00	0.45	0.06	1.51	2	XXX
74000		A	X-RAY EXAM OF ABDOMEN	0.19	0.61	0.04	0.84	2	XXX
74000	TC	A	X-RAY EXAM OF ABDOMEN	0.00	0.53	0.03	0.56		XXX
74000	26	A	X-RAY EXAM OF ABDOMEN	0.19	0.08	0.01	0.28	2	XXX
74010		A	X-RAY EXAM OF ABDOMEN	0.24	0.69	0.06	0.99	2	XXX
74010	TC	A	X-RAY EXAM OF ABDOMEN	0.00	0.58	0.04	0.62		XXX
74010	26	A	X-RAY EXAM OF ABDOMEN	0.24	0.11	0.02	0.37	2	XXX
74020		A	X-RAY EXAM OF ABDOMEN	0.28	0.76	0.06	1.10	2	XXX
74020	TC	A	X-RAY EXAM OF ABDOMEN	0.00	0.63	0.04	0.67		XXX
74020	26	A	X-RAY EXAM OF ABDOMEN	0.28	0.13	0.02	0.43	2	XXX
74022		A	X-RAY EXAM SERIES, ABDOMEN	0.33	0.89	0.07	1.29	2	XXX
74022	TC	A	X-RAY EXAM SERIES, ABDOMEN	0.00	0.74	0.05	0.79		XXX
74022	26	A	X-RAY EXAM SERIES, ABDOMEN	0.33	0.15	0.02	0.50	2	XXX
74150		A	CAT SCAN OF ABDOMEN	1.25	6.24	0.44	7.93	2	XXX
74150	TC	A	CAT SCAN OF ABDOMEN	0.00	5.68	0.36	6.04		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
74150	26	A	CAT SCAN OF ABDOMEN	1.25	0.56	0.08	1.89	2	XXX
74160		A	CONTRAST CAT SCAN OF ABDOMEN	1.34	7.47	0.52	9.33	2	XXX
74160	TC	A	CONTRAST CAT SCAN OF ABDOMEN	0.00	6.87	0.43	7.30		XXX
74160	26	A	CONTRAST CAT SCAN OF ABDOMEN	1.34	0.60	0.09	2.03	2	XXX
74170		A	CONTRAST CAT SCANS, ABDOMEN	1.48	9.19	0.63	11.30	2	XXX
74170	TC	A	CONTRAST CAT SCANS, ABDOMEN	0.00	8.53	0.53	9.06		XXX
74170	26	A	CONTRAST CAT SCANS, ABDOMEN	1.48	0.66	0.10	2.24	2	XXX
74181		A	MAGNETIC IMAGE, ABDOMEN(MRI)	1.69	12.01	0.82	14.52	2	XXX
74181	TC	A	MAGNETIC IMAGE, ABDOMEN(MRI)	0.00	11.25	0.71	11.96		XXX
74181	26	A	MAGNETIC IMAGE, ABDOMEN(MRI)	1.69	0.76	0.11	2.56	2	XXX
74210		A	CONTRAST XRAY EXAM OF THROAT	0.37	1.34	0.09	1.80	2	XXX
74210	TC	A	CONTRAST XRAY EXAM OF THROAT	0.00	1.18	0.07	1.25		XXX
74210	26	A	CONTRAST XRAY EXAM OF THROAT	0.37	0.16	0.02	0.55	2	XXX
74220		A	CONTRAST XRAY EXAM, ESOPHAGUS	0.49	1.40	0.10	1.99	2	XXX
74220	TC	A	CONTRAST XRAY EXAM, ESOPHAGUS	0.00	1.18	0.07	1.25		XXX
74220	26	A	CONTRAST XRAY EXAM, ESOPHAGUS	0.49	0.22	0.03	0.74	2	XXX
74230		A	CINEMA XRAY THROAT/ESOPHAGUS	0.57	1.57	0.12	2.26	2	XXX
74230	TC	A	CINEMA XRAY THROAT/ESOPHAGUS	0.00	1.31	0.08	1.39		XXX
74230	26	A	CINEMA XRAY THROAT/ESOPHAGUS	0.57	0.26	0.04	0.87	2	XXX
74235		A	REMOVE ESOPHAGUS OBSTRUCTION	1.25	3.19	0.25	4.69	2	XXX
74235	TC	A	REMOVE ESOPHAGUS OBSTRUCTION	0.00	2.63	0.17	2.80		XXX
74235	26	A	REMOVE ESOPHAGUS OBSTRUCTION	1.25	0.56	0.08	1.89	2	XXX
74240		A	X-RAY EXAM UPPER GI TRACT	0.73	1.80	0.14	2.67	2	XXX
74240	TC	A	X-RAY EXAM UPPER GI TRACT	0.00	1.47	0.09	1.56		XXX
74240	26	A	X-RAY EXAM UPPER GI TRACT	0.73	0.33	0.05	1.11	2	XXX
74241		A	X-RAY EXAM UPPER GI TRACT	0.73	1.83	0.14	2.70	2	XXX
74241	TC	A	X-RAY EXAM UPPER GI TRACT	0.00	1.50	0.09	1.59		XXX
74241	26	A	X-RAY EXAM UPPER GI TRACT	0.73	0.33	0.05	1.11	2	XXX
74245		A	X-RAY EXAM UPPER GI TRACT	0.96	2.83	0.21	4.00	2	XXX
74245	TC	A	X-RAY EXAM UPPER GI TRACT	0.00	2.40	0.15	2.55		XXX
74245	26	A	X-RAY EXAM UPPER GI TRACT	0.96	0.43	0.06	1.45	2	XXX
74246		A	CONTRAST XRAY UPPER GI TRACT	0.73	1.99	0.15	2.87	2	XXX
74246	TC	A	CONTRAST XRAY UPPER GI TRACT	0.00	1.66	0.10	1.76		XXX
74246	26	A	CONTRAST XRAY UPPER GI TRACT	0.73	0.33	0.05	1.11	2	XXX
74247		A	CONTRAST XRAY UPPER GI TRACT	0.73	2.02	0.16	2.91	2	XXX
74247	TC	A	CONTRAST XRAY UPPER GI TRACT	0.00	1.69	0.11	1.80		XXX
74247	26	A	CONTRAST XRAY UPPER GI TRACT	0.73	0.33	0.05	1.11	2	XXX
74249		A	CONTRAST XRAY UPPER GI TRACT	0.96	3.01	0.22	4.19	2	XXX
74249	TC	A	CONTRAST XRAY UPPER GI TRACT	0.00	2.58	0.16	2.74		XXX
74249	26	A	CONTRAST XRAY UPPER GI TRACT	0.96	0.43	0.06	1.45	2	XXX
74250		A	X-RAY EXAM OF SMALL BOWEL	0.50	1.53	0.11	2.14	2	XXX
74250	TC	A	X-RAY EXAM OF SMALL BOWEL	0.00	1.31	0.08	1.39		XXX
74250	26	A	X-RAY EXAM OF SMALL BOWEL	0.50	0.22	0.03	0.75	2	XXX
74260		A	X-RAY EXAM OF SMALL BOWEL	0.54	1.74	0.12	2.40	2	XXX
74260	TC	A	X-RAY EXAM OF SMALL BOWEL	0.00	1.50	0.09	1.59		XXX
74260	26	A	X-RAY EXAM OF SMALL BOWEL	0.54	0.24	0.03	0.81	2	XXX
74270		A	CONTRAST X-RAY EXAM OF COLON	0.73	2.04	0.16	2.93	2	XXX
74270	TC	A	CONTRAST X-RAY EXAM OF COLON	0.00	1.71	0.11	1.82		XXX
74270	26	A	CONTRAST X-RAY EXAM OF COLON	0.73	0.33	0.05	1.11	2	XXX
74280		A	CONTRAST X-RAY EXAM OF COLON	1.04	2.71	0.21	3.96	2	XXX
74280	TC	A	CONTRAST X-RAY EXAM OF COLON	0.00	2.24	0.14	2.38		XXX
74280	26	A	CONTRAST X-RAY EXAM OF COLON	1.04	0.47	0.07	1.58	2	XXX
74283		A	CONTRAST X-RAY EXAM OF COLON	2.13	3.52	0.30	5.95	2	XXX
74283	TC	A	CONTRAST X-RAY EXAM OF COLON	0.00	2.57	0.16	2.73		XXX
74283	26	A	CONTRAST X-RAY EXAM OF COLON	2.13	0.95	0.14	3.22	2	XXX
74290		A	CONTRAST X-RAY, GALLBLADDER	0.33	0.89	0.07	1.29	2	XXX
74290	TC	A	CONTRAST X-RAY, GALLBLADDER	0.00	0.74	0.05	0.79		XXX
74290	26	A	CONTRAST X-RAY, GALLBLADDER	0.33	0.15	0.02	0.50	2	XXX
74291		A	CONTRAST X-RAYS, GALLBLADDER	0.21	0.51	0.04	0.76	2	XXX
74291	TC	A	CONTRAST X-RAYS, GALLBLADDER	0.00	0.42	0.03	0.45		XXX
74291	26	A	CONTRAST X-RAYS, GALLBLADDER	0.21	0.09	0.01	0.31	2	XXX
74300		C	X-RAY BILE DUCTS, PANCREAS	0.00	0.00	0.00	0.00		XXX
74300	TC	C	X-RAY BILE DUCTS, PANCREAS	0.00	0.00	0.00	0.00		XXX
74300	26	A	X-RAY BILE DUCTS, PANCREAS	0.37	0.17	0.02	0.56	2	XXX
74301		C	ADDITIONAL X-RAYS AT SURGERY	0.00	0.00	0.00	0.00		XXX
74301	TC	C	ADDITIONAL X-RAYS AT SURGERY	0.00	0.00	0.00	0.00		XXX
74301	26	A	ADDITIONAL X-RAYS AT SURGERY	0.22	0.10	0.01	0.33	2	XXX
74305		A	X-RAY BILE DUCTS, PANCREAS	0.44	0.99	0.08	1.51	2	XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
74305	TC	A	X-RAY BILE DUCTS, PANCREAS	0.00	0.79	0.05	0.84		XXX
74305	26	A	X-RAY BILE DUCTS, PANCREAS	0.44	0.20	0.03	0.67	2	XXX
74320		A	CONTRAST X-RAY OF BILE DUCTS	0.58	3.42	0.24	4.24	2	XXX
74320	TC	A	CONTRAST X-RAY OF BILE DUCTS	0.00	3.16	0.20	3.36		XXX
74320	26	A	CONTRAST X-RAY OF BILE DUCTS	0.58	0.26	0.04	0.88	2	XXX
74321		D	CONTRAST X-RAY OF BILE DUCTS	0.00	0.00	0.00	0.00		XXX
74327		A	X-RAY FOR BILE STONE REMOVAL	0.74	2.10	0.16	3.00	2	XXX
74327	TC	A	X-RAY FOR BILE STONE REMOVAL	0.00	1.77	0.11	1.88		XXX
74327	26	A	X-RAY FOR BILE STONE REMOVAL	0.74	0.33	0.05	1.12	2	XXX
74328		A	XRAY FOR BILE DUCT ENDOSCOPY	0.74	3.49	0.25	4.48	2	XXX
74328	TC	A	XRAY FOR BILE DUCT ENDOSCOPY	0.00	3.16	0.20	3.36		XXX
74328	26	A	XRAY FOR BILE DUCT ENDOSCOPY	0.74	0.33	0.05	1.12	2	XXX
74329		A	X-RAY FOR PANCREAS ENDOSCOPY	0.74	3.49	0.25	4.48	2	XXX
74329	TC	A	X-RAY FOR PANCREAS ENDOSCOPY	0.00	3.16	0.20	3.36		XXX
74329	26	A	X-RAY FOR PANCREAS ENDOSCOPY	0.74	0.33	0.05	1.12	2	XXX
74330		A	XRAY,BILE/PANCREAS ENDOSCOPY	0.74	3.49	0.25	4.48	2	XXX
74330	TC	A	XRAY,BILE/PANCREAS ENDOSCOPY	0.00	3.16	0.20	3.36		XXX
74330	26	A	XRAY,BILE/PANCREAS ENDOSCOPY	0.74	0.33	0.05	1.12	2	XXX
74340		A	X-RAY GUIDE FOR GI TUBE	0.58	2.89	0.21	3.68	2	XXX
74340	TC	A	X-RAY GUIDE FOR GI TUBE	0.00	2.63	0.17	2.80		XXX
74340	26	A	X-RAY GUIDE FOR GI TUBE	0.58	0.26	0.04	0.88	2	XXX
74350		A	X-RAY GUIDE, STOMACH TUBE	0.80	3.52	0.25	4.57	2	XXX
74350	TC	A	X-RAY GUIDE, STOMACH TUBE	0.00	3.16	0.20	3.36		XXX
74350	26	A	X-RAY GUIDE, STOMACH TUBE	0.80	0.36	0.05	1.21	2	XXX
74351		D	X-RAY GUIDE, STOMACH TUBE	0.00	0.00	0.00	0.00		XXX
74355		A	X-RAY GUIDE, INTESTINAL TUBE	0.80	2.99	0.22	4.01	2	XXX
74355	TC	A	X-RAY GUIDE, INTESTINAL TUBE	0.00	2.63	0.17	2.80		XXX
74355	26	A	X-RAY GUIDE, INTESTINAL TUBE	0.80	0.36	0.05	1.21	2	XXX
74356		D	X-RAY GUIDE, INTESTINAL TUBE	0.00	0.00	0.00	0.00		XXX
74360		A	X-RAY GUIDE, GI DILATION	0.58	3.42	0.24	4.24	2	XXX
74360	TC	A	X-RAY GUIDE, GI DILATION	0.00	3.16	0.20	3.36		XXX
74360	26	A	X-RAY GUIDE, GI DILATION	0.58	0.26	0.04	0.88	2	XXX
74361		D	X-RAY GUIDE, GI DILATION	0.00	0.00	0.00	0.00		XXX
74363		C	X-RAY, BILE DUCT DILATATION	0.00	0.00	0.00	0.00		XXX
74363	TC	C	X-RAY, BILE DUCT DILATATION	0.00	0.00	0.00	0.00		XXX
74363	26	A	X-RAY, BILE DUCT DILATATION	0.93	0.42	0.06	1.41	2	XXX
74400		A	CONTRAST X-RAY URINARY TRACT	0.52	1.92	0.14	2.58	2	XXX
74400	TC	A	CONTRAST X-RAY URINARY TRACT	0.00	1.69	0.11	1.80		XXX
74400	26	A	CONTRAST X-RAY URINARY TRACT	0.52	0.23	0.03	0.78	2	XXX
74405		A	CONTRAST X-RAY URINARY TRACT	0.52	2.23	0.16	2.91	2	XXX
74405	TC	A	CONTRAST X-RAY URINARY TRACT	0.00	2.00	0.13	2.13		XXX
74405	26	A	CONTRAST X-RAY URINARY TRACT	0.52	0.23	0.03	0.78	2	XXX
74410		A	CONTRAST X-RAY URINARY TRACT	0.52	2.18	0.15	2.85	2	XXX
74410	TC	A	CONTRAST X-RAY URINARY TRACT	0.00	1.95	0.12	2.07		XXX
74410	26	A	CONTRAST X-RAY URINARY TRACT	0.52	0.23	0.03	0.78	2	XXX
74415		A	CONTRAST X-RAY URINARY TRACT	0.52	2.36	0.16	3.04	2	XXX
74415	TC	A	CONTRAST X-RAY URINARY TRACT	0.00	2.13	0.13	2.26		XXX
74415	26	A	CONTRAST X-RAY URINARY TRACT	0.52	0.23	0.03	0.78	2	XXX
74420		A	CONTRAST X-RAY URINARY TRACT	0.37	2.79	0.19	3.35	2	XXX
74420	TC	A	CONTRAST X-RAY URINARY TRACT	0.00	2.63	0.17	2.80		XXX
74420	26	A	CONTRAST X-RAY URINARY TRACT	0.37	0.16	0.02	0.55	2	XXX
74425		A	CONTRAST X-RAY URINARY TRACT	0.37	1.47	0.10	1.94	2	XXX
74425	TC	A	CONTRAST X-RAY URINARY TRACT	0.00	1.31	0.08	1.39		XXX
74425	26	A	CONTRAST X-RAY URINARY TRACT	0.37	0.16	0.02	0.55	2	XXX
74426		D	CONTRAST X-RAY URINARY TRACT	0.00	0.00	0.00	0.00		XXX
74430		A	CONTRAST X-RAY OF BLADDER	0.33	1.20	0.09	1.62	2	XXX
74430	TC	A	CONTRAST X-RAY OF BLADDER	0.00	1.05	0.07	1.12		XXX
74430	26	A	CONTRAST X-RAY OF BLADDER	0.33	0.15	0.02	0.50	2	XXX
74431		D	CONTRAST X-RAY OF BLADDER	0.00	0.00	0.00	0.00		XXX
74440		A	XRAY EXAM MALE GENITAL TRACT	0.39	1.30	0.10	1.79	2	XXX
74440	TC	A	XRAY EXAM MALE GENITAL TRACT	0.00	1.13	0.07	1.20		XXX
74440	26	A	XRAY EXAM MALE GENITAL TRACT	0.39	0.17	0.03	0.59	2	XXX
74441		D	XRAY EXAM MALE GENITAL TRACT	0.00	0.00	0.00	0.00		XXX
74445		A	X-RAY EXAM OF PENIS	1.20	1.67	0.15	3.02	2	XXX
74445	TC	A	X-RAY EXAM OF PENIS	0.00	1.13	0.07	1.20		XXX
74445	26	A	X-RAY EXAM OF PENIS	1.20	0.54	0.08	1.82	2	XXX
74446		D	X-RAY EXAM OF PENIS	0.00	0.00	0.00	0.00		XXX
74450		A	X-RAY EXAM URETHRA/BLADDER	0.34	1.62	0.11	2.07	2	XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
74450	TC	A	X-RAY EXAM URETHRA/BLADDER	0.00	1.47	0.09	1.56		XXX
74450	26	A	X-RAY EXAM URETHRA/BLADDER	0.34	0.15	0.02	0.51	2	XXX
74451		D	X-RAY EXAM URETHRA/BLADDER	0.00	0.00	0.00	0.00		XXX
74455		A	X-RAY EXAM URETHRA/BLADDER	0.34	1.73	0.12	2.19	2	XXX
74455	TC	A	X-RAY EXAM URETHRA/BLADDER	0.00	1.58	0.10	1.68		XXX
74455	26	A	X-RAY EXAM URETHRA/BLADDER	0.34	0.15	0.02	0.51	2	XXX
74456		D	X-RAY EXAM URETHRA/BLADDER	0.00	0.00	0.00	0.00		XXX
74470		A	X-RAY EXAM OF KIDNEY LESION	0.58	1.52	0.12	2.22	2	XXX
74470	TC	A	X-RAY EXAM OF KIDNEY LESION	0.00	1.26	0.08	1.34		XXX
74470	26	A	X-RAY EXAM OF KIDNEY LESION	0.58	0.26	0.04	0.88	2	XXX
74471		D	X-RAY EXAM OF KIDNEY LESION	0.00	0.00	0.00	0.00		XXX
74475		A	XRAY CONTROL CATHETER INSERT	0.58	4.34	0.30	5.22	2	XXX
74475	TC	A	XRAY CONTROL CATHETER INSERT	0.00	4.08	0.26	4.34		XXX
74475	26	A	XRAY CONTROL CATHETER INSERT	0.58	0.26	0.04	0.88	2	XXX
74476		D	XRAY CONTROL CATHETER INSERT	0.00	0.00	0.00	0.00		XXX
74480		A	XRAY CONTROL CATHETER INSERT	0.58	4.34	0.30	5.22	2	XXX
74480	TC	A	XRAY CONTROL CATHETER INSERT	0.00	4.08	0.26	4.34		XXX
74480	26	A	XRAY CONTROL CATHETER INSERT	0.58	0.26	0.04	0.88	2	XXX
74481		D	XRAY CONTROL CATHETER INSERT	0.00	0.00	0.00	0.00		XXX
74485		A	X-RAY GUIDE, GU DILATION	0.58	3.42	0.24	4.24	2	XXX
74485	TC	A	X-RAY GUIDE, GU DILATION	0.00	3.16	0.20	3.36		XXX
74485	26	A	X-RAY GUIDE, GU DILATION	0.58	0.26	0.04	0.88	2	XXX
74486		D	X-RAY GUIDE, GU DILATION	0.00	0.00	0.00	0.00		XXX
74710		A	X-RAY MEASUREMENT OF PELVIS	0.35	1.21	0.09	1.65	2	XXX
74710	TC	A	X-RAY MEASUREMENT OF PELVIS	0.00	1.05	0.07	1.12		XXX
74710	26	A	X-RAY MEASUREMENT OF PELVIS	0.35	0.16	0.02	0.53	2	XXX
74740		A	X-RAY FEMALE GENITAL TRACT	0.39	1.48	0.11	1.98	2	XXX
74740	TC	A	X-RAY FEMALE GENITAL TRACT	0.00	1.31	0.08	1.39		XXX
74740	26	A	X-RAY FEMALE GENITAL TRACT	0.39	0.17	0.03	0.59	2	XXX
74741		D	X-RAY FEMALE GENITAL TRACT	0.00	0.00	0.00	0.00		XXX
74775		A	X-RAY EXAM OF PERINEUM	0.66	1.77	0.13	2.56	2	XXX
74775	TC	A	X-RAY EXAM OF PERINEUM	0.00	1.47	0.09	1.56		XXX
74775	26	A	X-RAY EXAM OF PERINEUM	0.66	0.30	0.04	1.00	2	XXX
75500		A	CINEMA X-RAY HEART VESSELS	1.20	12.13	0.81	14.14	2	XXX
75500	TC	A	CINEMA X-RAY HEART VESSELS	0.00	11.59	0.73	12.32		XXX
75500	26	A	CINEMA X-RAY HEART VESSELS	1.20	0.54	0.08	1.82	2	XXX
75501		D	CINEMA X-RAY HEART VESSELS	0.00	0.00	0.00	0.00		XXX
75505		A	X-RAY EXAM OF HEART VESSELS	1.20	12.13	0.81	14.14	2	XXX
75505	TC	A	X-RAY EXAM OF HEART VESSELS	0.00	11.59	0.73	12.32		XXX
75505	26	A	X-RAY EXAM OF HEART VESSELS	1.20	0.54	0.08	1.82	2	XXX
75506		D	X-RAY EXAM OF HEART VESSELS	0.00	0.00	0.00	0.00		XXX
75507		A	X-RAY EXAM OF HEART VESSELS	1.38	12.21	0.82	14.41	2	XXX
75507	TC	A	X-RAY EXAM OF HEART VESSELS	0.00	11.59	0.73	12.32		XXX
75507	26	A	X-RAY EXAM OF HEART VESSELS	1.38	0.62	0.09	2.09	2	XXX
75509		D	X-RAY EXAM OF HEART VESSELS	0.00	0.00	0.00	0.00		XXX
75519		A	HEART X-RAY/CATHETERIZATION	0.88	11.99	0.79	13.66	2	XXX
75519	TC	A	HEART X-RAY/CATHETERIZATION	0.00	11.59	0.73	12.32		XXX
75519	26	A	HEART X-RAY/CATHETERIZATION	0.88	0.40	0.06	1.34	2	XXX
75520		D	HEART X-RAY/CATHETERIZATION	0.00	0.00	0.00	0.00		XXX
75523		A	HEART X-RAY/CATHETERIZATION	0.88	11.99	0.79	13.66	2	XXX
75523	TC	A	HEART X-RAY/CATHETERIZATION	0.00	11.59	0.73	12.32		XXX
75523	26	A	HEART X-RAY/CATHETERIZATION	0.88	0.40	0.06	1.34	2	XXX
75524		D	HEART X-RAY/CATHETERIZATION	0.00	0.00	0.00	0.00		XXX
75527		A	HEART X-RAY/CATHETERIZATION	1.58	12.30	0.83	14.71	2	XXX
75527	TC	A	HEART X-RAY/CATHETERIZATION	0.00	11.59	0.73	12.32		XXX
75527	26	A	HEART X-RAY/CATHETERIZATION	1.58	0.71	0.10	2.39	2	XXX
75528		D	HEART X-RAY/CATHETERIZATION	0.00	0.00	0.00	0.00		XXX
75552		A	MAGNETIC IMAGE, MYOCARDIUM	1.69	12.01	0.82	14.52	2	XXX
75552	TC	A	MAGNETIC IMAGE, MYOCARDIUM	0.00	11.25	0.71	11.96		XXX
75552	26	A	MAGNETIC IMAGE, MYOCARDIUM	1.69	0.76	0.11	2.56	2	XXX
75600		A	CONTRAST X-RAY EXAM OF AORTA	0.52	12.88	0.82	14.22	2	XXX
75600	TC	A	CONTRAST X-RAY EXAM OF AORTA	0.00	12.65	0.79	13.44		XXX
75600	26	A	CONTRAST X-RAY EXAM OF AORTA	0.52	0.23	0.03	0.78	2	XXX
75601		D	CONTRAST X-RAY EXAM OF AORTA	0.00	0.00	0.00	0.00		XXX
75605		A	CONTRAST X-RAY EXAM OF AORTA	1.20	13.19	0.87	15.26	2	XXX
75605	TC	A	CONTRAST X-RAY EXAM OF AORTA	0.00	12.65	0.79	13.44		XXX
75605	26	A	CONTRAST X-RAY EXAM OF AORTA	1.20	0.54	0.08	1.82	2	XXX
75606		D	CONTRAST X-RAY EXAM OF AORTA	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
75625		A	CONTRAST X-RAY EXAM OF AORTA	1.20	13.19	0.87	15.26	2	XXX
75625	TC	A	CONTRAST X-RAY EXAM OF AORTA	0.00	12.65	0.79	13.44		XXX
75625	26	A	CONTRAST X-RAY EXAM OF AORTA	1.20	0.54	0.08	1.82	2	XXX
75626		D	CONTRAST X-RAY EXAM OF AORTA	0.00	0.00	0.00	0.00		XXX
75627		D	CONTRAST X-RAY EXAM OF AORTA	0.00	0.00	0.00	0.00		XXX
75628		D	CONTRAST X-RAY EXAM OF AORTA	0.00	0.00	0.00	0.00		XXX
75630		A	X-RAY AORTA, LEG ARTERIES	1.38	13.81	0.92	16.11	2	XXX
75630	TC	A	X-RAY AORTA, LEG ARTERIES	0.00	13.19	0.83	14.02		XXX
75630	26	A	X-RAY AORTA, LEG ARTERIES	1.38	0.62	0.09	2.09	2	XXX
75631		D	X-RAY AORTA, LEG ARTERIES	0.00	0.00	0.00	0.00		XXX
75650		A	ARTERY X-RAYS, HEAD & NECK	1.57	13.35	0.89	15.81	2	XXX
75650	TC	A	ARTERY X-RAYS, HEAD & NECK	0.00	12.65	0.79	13.44		XXX
75650	26	A	ARTERY X-RAYS, HEAD & NECK	1.57	0.70	0.10	2.37	2	XXX
75651		D	ARTERY X-RAYS, HEAD & NECK	0.00	0.00	0.00	0.00		XXX
75652		D	ARTERY X-RAYS, HEAD & NECK	0.00	0.00	0.00	0.00		XXX
75653		D	ARTERY X-RAYS, HEAD & NECK	0.00	0.00	0.00	0.00		XXX
75654		D	ARTERY X-RAYS, HEAD & NECK	0.00	0.00	0.00	0.00		XXX
75655		D	ARTERY X-RAYS, HEAD & NECK	0.00	0.00	0.00	0.00		XXX
75656		D	ARTERY X-RAYS, HEAD & NECK	0.00	0.00	0.00	0.00		XXX
75657		D	ARTERY X-RAYS, HEAD & NECK	0.00	0.00	0.00	0.00		XXX
75658		A	X-RAY EXAM OF ARM ARTERIES	1.38	13.27	0.88	15.53	2	XXX
75658	TC	A	X-RAY EXAM OF ARM ARTERIES	0.00	12.65	0.79	13.44		XXX
75658	26	A	X-RAY EXAM OF ARM ARTERIES	1.38	0.62	0.09	2.09	2	XXX
75659		D	X-RAY EXAM OF ARM ARTERIES	0.00	0.00	0.00	0.00		XXX
75660		A	ARTERY X-RAYS, HEAD & NECK	1.38	13.27	0.88	15.53	2	XXX
75660	TC	A	ARTERY X-RAYS, HEAD & NECK	0.00	12.65	0.79	13.44		XXX
75660	26	A	ARTERY X-RAYS, HEAD & NECK	1.38	0.62	0.09	2.09	2	XXX
75661		D	ARTERY X-RAYS, HEAD & NECK	0.00	0.00	0.00	0.00		XXX
75662		A	ARTERY X-RAYS, HEAD & NECK	1.75	13.43	0.90	16.08	2	XXX
75662	TC	A	ARTERY X-RAYS, HEAD & NECK	0.00	12.65	0.79	13.44		XXX
75662	26	A	ARTERY X-RAYS, HEAD & NECK	1.75	0.78	0.11	2.64	2	XXX
75663		D	ARTERY X-RAYS, HEAD & NECK	0.00	0.00	0.00	0.00		XXX
75665		A	ARTERY X-RAYS, HEAD & NECK	1.38	13.27	0.88	15.53	2	XXX
75665	TC	A	ARTERY X-RAYS, HEAD & NECK	0.00	12.65	0.79	13.44		XXX
75665	26	A	ARTERY X-RAYS, HEAD & NECK	1.38	0.62	0.09	2.09	2	XXX
75667		D	ARTERY X-RAYS, HEAD & NECK	0.00	0.00	0.00	0.00		XXX
75669		D	ARTERY X-RAYS, HEAD & NECK	0.00	0.00	0.00	0.00		XXX
75671		A	ARTERY X-RAYS, HEAD & NECK	1.75	13.43	0.90	16.08	2	XXX
75671	TC	A	ARTERY X-RAYS, HEAD & NECK	0.00	12.65	0.79	13.44		XXX
75671	26	A	ARTERY X-RAYS, HEAD & NECK	1.75	0.78	0.11	2.64	2	XXX
75672		D	ARTERY X-RAYS, HEAD & NECK	0.00	0.00	0.00	0.00		XXX
75673		D	ARTERY X-RAYS, HEAD & NECK	0.00	0.00	0.00	0.00		XXX
75676		A	ARTERY X-RAYS, NECK	1.38	13.27	0.88	15.53	2	XXX
75676	TC	A	ARTERY X-RAYS, NECK	0.00	12.65	0.79	13.44		XXX
75676	26	A	ARTERY X-RAYS, NECK	1.38	0.62	0.09	2.09	2	XXX
75677		D	ARTERY X-RAYS, NECK	0.00	0.00	0.00	0.00		XXX
75678		D	ARTERY X-RAYS, NECK	0.00	0.00	0.00	0.00		XXX
75680		A	ARTERY X-RAYS, NECK	1.75	13.43	0.90	16.08	2	XXX
75680	TC	A	ARTERY X-RAYS, NECK	0.00	12.65	0.79	13.44		XXX
75680	26	A	ARTERY X-RAYS, NECK	1.75	0.78	0.11	2.64	2	XXX
75681		D	ARTERY X-RAYS, NECK	0.00	0.00	0.00	0.00		XXX
75682		D	ARTERY X-RAYS, NECK	0.00	0.00	0.00	0.00		XXX
75685		A	ARTERY X-RAYS, SPINE	1.38	13.27	0.88	15.53	2	XXX
75685	TC	A	ARTERY X-RAYS, SPINE	0.00	12.65	0.79	13.44		XXX
75685	26	A	ARTERY X-RAYS, SPINE	1.38	0.62	0.09	2.09	2	XXX
75687		D	ARTERY X-RAYS, SPINE	0.00	0.00	0.00	0.00		XXX
75690		D	ARTERY X-RAYS, NECK SPINE	0.00	0.00	0.00	0.00		XXX
75692		D	ARTERY X-RAYS, NECK SPINE	0.00	0.00	0.00	0.00		XXX
75695		D	ARTERY X-RAYS, NECK SPINE	0.00	0.00	0.00	0.00		XXX
75697		D	ARTERY X-RAYS, NECK SPINE	0.00	0.00	0.00	0.00		XXX
75705		A	ARTERY X-RAYS, SPINE	2.29	13.68	0.94	16.91	2	XXX
75705	TC	A	ARTERY X-RAYS, SPINE	0.00	12.65	0.79	13.44		XXX
75705	26	A	ARTERY X-RAYS, SPINE	2.29	1.03	0.15	3.47	2	XXX
75706		D	ARTERY X-RAYS, SPINE	0.00	0.00	0.00	0.00		XXX
75710		A	ARTERY X-RAYS, ARM/LEG	1.20	13.19	0.87	15.26	2	XXX
75710	TC	A	ARTERY X-RAYS, ARM/LEG	0.00	12.65	0.79	13.44		XXX
75710	26	A	ARTERY X-RAYS, ARM/LEG	1.20	0.54	0.08	1.82	2	XXX
75711		D	ARTERY X-RAYS, ARM/LEG	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
75712		D	ARTERY X-RAYS, ARM/LEG	0.00	0.00	0.00	0.00		XXX
75716		A	ARTERY X-RAYS, ARMS/LEGS	1.38	13.27	0.88	15.53	2	XXX
75716	TC	A	ARTERY X-RAYS, ARMS/LEGS	0.00	12.65	0.79	13.44		XXX
75716	26	A	ARTERY X-RAYS, ARMS/LEGS	1.38	0.62	0.09	2.09	2	XXX
75717		D	ARTERY X-RAYS, ARMS/LEGS	0.00	0.00	0.00	0.00		XXX
75718		D	ARTERY X-RAYS, ARMS/LEGS	0.00	0.00	0.00	0.00		XXX
75722		A	ARTERY X-RAYS, KIDNEY	1.20	13.19	0.87	15.26	2	XXX
75722	TC	A	ARTERY X-RAYS, KIDNEY	0.00	12.65	0.79	13.44		XXX
75722	26	A	ARTERY X-RAYS, KIDNEY	1.20	0.54	0.08	1.82	2	XXX
75723		D	ARTERY X-RAYS, KIDNEY	0.00	0.00	0.00	0.00		XXX
75724		A	ARTERY X-RAYS, KIDNEYS	1.57	13.35	0.89	15.81	2	XXX
75724	TC	A	ARTERY X-RAYS, KIDNEYS	0.00	12.65	0.79	13.44		XXX
75724	26	A	ARTERY X-RAYS, KIDNEYS	1.57	0.70	0.10	2.37	2	XXX
75725		D	ARTERY X-RAYS, KIDNEYS	0.00	0.00	0.00	0.00		XXX
75726		A	ARTERY X-RAYS, ABDOMEN	1.20	13.19	0.87	15.26	2	XXX
75726	TC	A	ARTERY X-RAYS, ABDOMEN	0.00	12.65	0.79	13.44		XXX
75726	26	A	ARTERY X-RAYS, ABDOMEN	1.20	0.54	0.08	1.82	2	XXX
75727		D	ARTERY X-RAYS, ABDOMEN	0.00	0.00	0.00	0.00		XXX
75728		D	ARTERY X-RAYS, ABDOMEN	0.00	0.00	0.00	0.00		XXX
75731		A	ARTERY X-RAYS, ADRENAL GLAND	1.20	13.19	0.87	15.26	2	XXX
75731	TC	A	ARTERY X-RAYS, ADRENAL GLAND	0.00	12.65	0.79	13.44		XXX
75731	26	A	ARTERY X-RAYS, ADRENAL GLAND	1.20	0.54	0.08	1.82	2	XXX
75732		D	ARTERY X-RAYS, ADRENAL GLAND	0.00	0.00	0.00	0.00		XXX
75733		A	ARTERY X-RAYS, ADRENAL GLANDS	1.38	13.27	0.88	15.53	2	XXX
75733	TC	A	ARTERY X-RAYS, ADRENAL GLANDS	0.00	12.65	0.79	13.44		XXX
75733	26	A	ARTERY X-RAYS, ADRENAL GLANDS	1.38	0.62	0.09	2.09	2	XXX
75734		D	ARTERY X-RAYS, ADRENAL GLANDS	0.00	0.00	0.00	0.00		XXX
75736		A	ARTERY X-RAYS, PELVIS	1.20	13.19	0.87	15.26	2	XXX
75736	TC	A	ARTERY X-RAYS, PELVIS	0.00	12.65	0.79	13.44		XXX
75736	26	A	ARTERY X-RAYS, PELVIS	1.20	0.54	0.08	1.82	2	XXX
75737		D	ARTERY X-RAYS, PELVIS	0.00	0.00	0.00	0.00		XXX
75738		D	ARTERY X-RAYS, PELVIS	0.00	0.00	0.00	0.00		XXX
75741		A	ARTERY X-RAYS, LUNG	1.38	13.27	0.88	15.53	2	XXX
75741	TC	A	ARTERY X-RAYS, LUNG	0.00	12.65	0.79	13.44		XXX
75741	26	A	ARTERY X-RAYS, LUNG	1.38	0.62	0.09	2.09	2	XXX
75742		D	ARTERY X-RAYS, LUNG	0.00	0.00	0.00	0.00		XXX
75743		A	ARTERY X-RAYS, LUNGS	1.75	13.43	0.90	16.08	2	XXX
75743	TC	A	ARTERY X-RAYS, LUNGS	0.00	12.65	0.79	13.44		XXX
75743	26	A	ARTERY X-RAYS, LUNGS	1.75	0.78	0.11	2.64	2	XXX
75744		D	ARTERY X-RAYS, LUNGS	0.00	0.00	0.00	0.00		XXX
75746		A	ARTERY X-RAYS, LUNG	1.20	13.19	0.87	15.26	2	XXX
75746	TC	A	ARTERY X-RAYS, LUNG	0.00	12.65	0.79	13.44		XXX
75746	26	A	ARTERY X-RAYS, LUNG	1.20	0.54	0.08	1.82	2	XXX
75747		D	ARTERY X-RAYS, LUNG	0.00	0.00	0.00	0.00		XXX
75748		D	ARTERY X-RAYS, LUNG	0.00	0.00	0.00	0.00		XXX
75750		A	ARTERY X-RAYS, HEART	1.20	13.19	0.87	15.26	2	XXX
75750	TC	A	ARTERY X-RAYS, HEART	0.00	12.65	0.79	13.44		XXX
75750	26	A	ARTERY X-RAYS, HEART	1.20	0.54	0.08	1.82	2	XXX
75751		D	ARTERY X-RAYS, HEART	0.00	0.00	0.00	0.00		XXX
75752		A	ARTERY X-RAYS, HEART	1.20	13.19	0.87	15.26	2	XXX
75752	TC	A	ARTERY X-RAYS, HEART	0.00	12.65	0.79	13.44		XXX
75752	26	A	ARTERY X-RAYS, HEART	1.20	0.54	0.08	1.82	2	XXX
75753		D	ARTERY X-RAYS, HEART	0.00	0.00	0.00	0.00		XXX
75754		A	ARTERY X-RAYS, HEART	1.39	13.27	0.88	15.54	2	XXX
75754	TC	A	ARTERY X-RAYS, HEART	0.00	12.65	0.79	13.44		XXX
75754	26	A	ARTERY X-RAYS, HEART	1.39	0.62	0.09	2.10	2	XXX
75755		D	ARTERY X-RAYS, HEART	0.00	0.00	0.00	0.00		XXX
75756		A	ARTERY X-RAYS, CHEST	1.20	13.19	0.87	15.26	2	XXX
75756	TC	A	ARTERY X-RAYS, CHEST	0.00	12.65	0.79	13.44		XXX
75756	26	A	ARTERY X-RAYS, CHEST	1.20	0.54	0.08	1.82	2	XXX
75757		D	ARTERY X-RAYS, CHEST	0.00	0.00	0.00	0.00		XXX
75762		A	CORONARY BYPASS X-RAY	1.20	13.19	0.87	15.26	2	XXX
75762	TC	A	CORONARY BYPASS X-RAY	0.00	12.65	0.79	13.44		XXX
75762	26	A	CORONARY BYPASS X-RAY	1.20	0.54	0.08	1.82	2	XXX
75764		D	CORONARY BYPASS X-RAY	0.00	0.00	0.00	0.00		XXX
75766		A	CORONARY BYPASS X-RAY	1.38	13.27	0.88	15.53	2	XXX
75766	TC	A	CORONARY BYPASS X-RAY	0.00	12.65	0.79	13.44		XXX
75766	26	A	CORONARY BYPASS X-RAY	1.38	0.62	0.09	2.09	2	XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCCPS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
75767		D	CORONARY BYPASS X-RAY	0.00	0.00	0.00	0.00		XXX
75774		A	ARTERY X-RAY, EACH VESSEL	0.37	12.81	0.81	13.99	2	XXX
75774	TC	A	ARTERY X-RAY, EACH VESSEL	0.00	12.65	0.79	13.44		XXX
75774	26	A	ARTERY X-RAY, EACH VESSEL	0.37	0.16	0.02	0.55	2	XXX
75775		D	ARTERY X-RAY, EACH VESSEL	0.00	0.00	0.00	0.00		XXX
75790		A	VISUALIZE A-V SHUNT	1.93	2.23	0.21	4.37	2	XXX
75790	TC	A	VISUALIZE A-V SHUNT	0.00	1.36	0.09	1.45		XXX
75790	26	A	VISUALIZE A-V SHUNT	1.93	0.87	0.12	2.92	2	XXX
75801		A	LYMPH VESSEL X-RAY, ARM/LEG	0.85	5.82	0.39	7.06	2	XXX
75801	TC	A	LYMPH VESSEL X-RAY, ARM/LEG	0.00	5.44	0.34	5.78		XXX
75801	26	A	LYMPH VESSEL X-RAY, ARM/LEG	0.85	0.38	0.05	1.28	2	XXX
75802		D	LYMPH VESSEL X-RAY, ARM/LEG	0.00	0.00	0.00	0.00		XXX
75803		A	LYMPH VESSEL X-RAY, ARMS/LEGS	1.23	5.99	0.42	7.64	2	XXX
75803	TC	A	LYMPH VESSEL X-RAY, ARMS/LEGS	0.00	5.44	0.34	5.78		XXX
75803	26	A	LYMPH VESSEL X-RAY, ARMS/LEGS	1.23	0.55	0.08	1.86	2	XXX
75804		D	LYMPH VESSEL X-RAY, ARMS/LEGS	0.00	0.00	0.00	0.00		XXX
75805		A	LYMPH VESSEL X-RAY, TRUNK	0.85	6.50	0.43	7.78	2	XXX
75805	TC	A	LYMPH VESSEL X-RAY, TRUNK	0.00	6.12	0.38	6.50		XXX
75805	26	A	LYMPH VESSEL X-RAY, TRUNK	0.85	0.38	0.05	1.28	2	XXX
75806		D	LYMPH VESSEL X-RAY, TRUNK	0.00	0.00	0.00	0.00		XXX
75807		A	LYMPH VESSEL X-RAY, TRUNK	1.23	6.67	0.46	8.36	2	XXX
75807	TC	A	LYMPH VESSEL X-RAY, TRUNK	0.00	6.12	0.38	6.50		XXX
75807	26	A	LYMPH VESSEL X-RAY, TRUNK	1.23	0.55	0.08	1.86	2	XXX
75808		D	LYMPH VESSEL X-RAY, TRUNK	0.00	0.00	0.00	0.00		XXX
75810		A	VEIN X-RAY, SPLEEN/LIVER	1.20	13.19	0.87	15.26	2	XXX
75810	TC	A	VEIN X-RAY, SPLEEN/LIVER	0.00	12.65	0.79	13.44		XXX
75810	26	A	VEIN X-RAY, SPLEEN/LIVER	1.20	0.54	0.08	1.82	2	XXX
75811		D	VEIN X-RAY, SPLEEN/LIVER	0.00	0.00	0.00	0.00		XXX
75820		A	VEIN X-RAY, ARM/LEG	0.74	1.28	0.11	2.13	2	XXX
75820	TC	A	VEIN X-RAY, ARM/LEG	0.00	0.95	0.06	1.01		XXX
75820	26	A	VEIN X-RAY, ARM/LEG	0.74	0.33	0.05	1.12	2	XXX
75821		D	VEIN X-RAY, ARM/LEG	0.00	0.00	0.00	0.00		XXX
75822		A	VEIN X-RAY, ARMS/LEGS	1.11	1.99	0.16	3.26	2	XXX
75822	TC	A	VEIN X-RAY, ARMS/LEGS	0.00	1.49	0.09	1.58		XXX
75822	26	A	VEIN X-RAY, ARMS/LEGS	1.11	0.50	0.07	1.68	2	XXX
75823		D	VEIN X-RAY, ARMS/LEGS	0.00	0.00	0.00	0.00		XXX
75825		A	VEIN X-RAY, TRUNK	1.20	13.19	0.87	15.26	2	XXX
75825	TC	A	VEIN X-RAY, TRUNK	0.00	12.65	0.79	13.44		XXX
75825	26	A	VEIN X-RAY, TRUNK	1.20	0.54	0.08	1.82	2	XXX
75826		D	VEIN X-RAY, TRUNK	0.00	0.00	0.00	0.00		XXX
75827		A	VEIN X-RAY, CHEST	1.20	13.19	0.87	15.26	2	XXX
75827	TC	A	VEIN X-RAY, CHEST	0.00	12.65	0.79	13.44		XXX
75827	26	A	VEIN X-RAY, CHEST	1.20	0.54	0.08	1.82	2	XXX
75828		D	VEIN X-RAY, CHEST	0.00	0.00	0.00	0.00		XXX
75831		A	VEIN X-RAY, KIDNEY	1.20	13.19	0.87	15.26	2	XXX
75831	TC	A	VEIN X-RAY, KIDNEY	0.00	12.65	0.79	13.44		XXX
75831	26	A	VEIN X-RAY, KIDNEY	1.20	0.54	0.08	1.82	2	XXX
75832		D	VEIN X-RAY, KIDNEY	0.00	0.00	0.00	0.00		XXX
75833		A	VEIN X-RAY, KIDNEYS	1.57	13.35	0.89	15.81	2	XXX
75833	TC	A	VEIN X-RAY, KIDNEYS	0.00	12.65	0.79	13.44		XXX
75833	26	A	VEIN X-RAY, KIDNEYS	1.57	0.70	0.10	2.37	2	XXX
75834		D	VEIN X-RAYS, KIDNEYS	0.00	0.00	0.00	0.00		XXX
75840		A	VEIN X-RAY, ADRENAL GLAND	1.20	13.19	0.87	15.26	2	XXX
75840	TC	A	VEIN X-RAY, ADRENAL GLAND	0.00	12.65	0.79	13.44		XXX
75840	26	A	VEIN X-RAY, ADRENAL GLAND	1.20	0.54	0.08	1.82	2	XXX
75841		D	VEIN X-RAY, ADRENAL GLAND	0.00	0.00	0.00	0.00		XXX
75842		A	VEIN X-RAY, ADRENAL GLANDS	1.57	13.35	0.89	15.81	2	XXX
75842	TC	A	VEIN X-RAY, ADRENAL GLANDS	0.00	12.65	0.79	13.44		XXX
75842	26	A	VEIN X-RAY, ADRENAL GLANDS	1.57	0.70	0.10	2.37	2	XXX
75843		D	VEIN X-RAY, ADRENAL GLANDS	0.00	0.00	0.00	0.00		XXX
75860		A	VEIN X-RAY, NECK	1.20	13.19	0.87	15.26	2	XXX
75860	TC	A	VEIN X-RAY, NECK	0.00	12.65	0.79	13.44		XXX
75860	26	A	VEIN X-RAY, NECK	1.20	0.54	0.08	1.82	2	XXX
75861		D	VEIN X-RAY, NECK	0.00	0.00	0.00	0.00		XXX
75870		A	VEIN X-RAY, SKULL	1.20	13.19	0.87	15.26	2	XXX
75870	TC	A	VEIN X-RAY, SKULL	0.00	12.65	0.79	13.44		XXX
75870	26	A	VEIN X-RAY, SKULL	1.20	0.54	0.08	1.82	2	XXX
75871		D	VEIN X-RAY, SKULL	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
75872		A	VEIN X-RAY, SKULL	1.20	13.19	0.87	15.26	2	XXX
75872	TC	A	VEIN X-RAY, SKULL	0.00	12.65	0.79	13.44		XXX
75872	26	A	VEIN X-RAY, SKULL	1.20	0.54	0.08	1.82	2	XXX
75873		D	VEIN X-RAY, SKULL	0.00	0.00	0.00	0.00		XXX
75880		A	VEIN X-RAY, EYE SOCKET	0.74	1.28	0.11	2.13	2	XXX
75880	TC	A	VEIN X-RAY, EYE SOCKET	0.00	0.95	0.06	1.01		XXX
75880	26	A	VEIN X-RAY, EYE SOCKET	0.74	0.33	0.05	1.12	2	XXX
75881		D	VEIN X-RAY, EYE SOCKET	0.00	0.00	0.00	0.00		XXX
75885		A	VEIN X-RAY, LIVER	1.52	13.33	0.89	15.74	2	XXX
75885	TC	A	VEIN X-RAY, LIVER	0.00	12.65	0.79	13.44		XXX
75885	26	A	VEIN X-RAY, LIVER	1.52	0.68	0.10	2.30	2	XXX
75886		D	VEIN X-RAY, LIVER	0.00	0.00	0.00	0.00		XXX
75887		A	VEIN X-RAY, LIVER	1.52	13.33	0.89	15.74	2	XXX
75887	TC	A	VEIN X-RAY, LIVER	0.00	12.65	0.79	13.44		XXX
75887	26	A	VEIN X-RAY, LIVER	1.52	0.68	0.10	2.30	2	XXX
75888		D	VEIN X-RAY, LIVER	0.00	0.00	0.00	0.00		XXX
75889		A	VEIN X-RAY, LIVER	1.20	13.19	0.87	15.26	2	XXX
75889	TC	A	VEIN X-RAY, LIVER	0.00	12.65	0.79	13.44		XXX
75889	26	A	VEIN X-RAY, LIVER	1.20	0.54	0.08	1.82	2	XXX
75890		D	VEIN X-RAY, LIVER	0.00	0.00	0.00	0.00		XXX
75891		A	VEIN X-RAY, LIVER	1.20	13.19	0.87	15.26	2	XXX
75891	TC	A	VEIN X-RAY, LIVER	0.00	12.65	0.79	13.44		XXX
75891	26	A	VEIN X-RAY, LIVER	1.20	0.54	0.08	1.82	2	XXX
75892		D	VEIN X-RAY, LIVER	0.00	0.00	0.00	0.00		XXX
75893		A	VENOUS SAMPLING BY CATHETER	0.58	12.91	0.83	14.32	2	XXX
75893	TC	A	VENOUS SAMPLING BY CATHETER	0.00	12.65	0.79	13.44		XXX
75893	26	A	VENOUS SAMPLING BY CATHETER	0.58	0.26	0.04	0.88	2	XXX
75894		A	XRAYS, TRANSCATHETER THERAPY	1.38	24.86	1.61	27.85	2	XXX
75894	TC	A	XRAYS, TRANSCATHETER THERAPY	0.00	24.24	1.52	25.76		XXX
75894	26	A	XRAYS, TRANSCATHETER THERAPY	1.38	0.62	0.09	2.09	2	XXX
75895		D	XRAYS, TRANSCATHETER THERAPY	0.00	0.00	0.00	0.00		XXX
75896		A	XRAYS, TRANSCATHETER THERAPY	1.38	21.70	1.41	24.49	2	XXX
75896	TC	A	XRAYS, TRANSCATHETER THERAPY	0.00	21.08	1.32	22.40		XXX
75896	26	A	XRAYS, TRANSCATHETER THERAPY	1.38	0.62	0.09	2.09	2	XXX
75897		D	XRAYS, TRANSCATHETER THERAPY	0.00	0.00	0.00	0.00		XXX
75898		A	FOLLOW-UP ANGIOGRAM	1.74	1.83	0.18	3.75	2	XXX
75898	TC	A	FOLLOW-UP ANGIOGRAM	0.00	1.05	0.07	1.12		XXX
75898	26	A	FOLLOW-UP ANGIOGRAM	1.74	0.78	0.11	2.63	2	XXX
75940		A	X-RAY PLACEMENT, VEIN FILTER	0.58	12.91	0.83	14.32	2	XXX
75940	TC	A	X-RAY PLACEMENT, VEIN FILTER	0.00	12.65	0.79	13.44		XXX
75940	26	A	X-RAY PLACEMENT, VEIN FILTER	0.58	0.26	0.04	0.88	2	XXX
75941		D	X-RAY PLACEMENT, VEIN FILTER	0.00	0.00	0.00	0.00		XXX
75950		D	VASCULAR BLOCK, TEMPORARY	0.00	0.00	0.00	0.00		XXX
75951		D	VASCULAR BLOCK, TEMPORARY	0.00	0.00	0.00	0.00		XXX
75955		D	VASCULAR BLOCK, PERMANENT	0.00	0.00	0.00	0.00		XXX
75956		D	VASCULAR BLOCK, PERMANENT	0.00	0.00	0.00	0.00		XXX
75961		A	TRANSCATHETER RETRIEVAL	4.48	12.55	0.95	17.98	2	XXX
75961	TC	A	TRANSCATHETER RETRIEVAL	0.00	10.54	0.66	11.20		XXX
75961	26	A	TRANSCATHETER RETRIEVAL	4.48	2.01	0.29	6.78	2	XXX
75962		A	REPAIR ARTERIAL BLOCKAGE	0.58	16.07	1.03	17.68	2	XXX
75962	TC	A	REPAIR ARTERIAL BLOCKAGE	0.00	15.81	0.99	16.80		XXX
75962	26	A	REPAIR ARTERIAL BLOCKAGE	0.58	0.26	0.04	0.88	2	XXX
75963		D	REPAIR ARTERIAL BLOCKAGE	0.00	0.00	0.00	0.00		XXX
75964		A	REPAIR ARTERY BLOCKAGE, EACH	0.37	8.59	0.55	9.51	2	XXX
75964	TC	A	REPAIR ARTERY BLOCKAGE, EACH	0.00	8.43	0.53	8.96		XXX
75964	26	A	REPAIR ARTERY BLOCKAGE, EACH	0.37	0.16	0.02	0.55	2	XXX
75965		D	REPAIR ARTERY BLOCKAGE, EACH	0.00	0.00	0.00	0.00		XXX
75966		A	REPAIR ARTERIAL BLOCKAGE	1.38	16.43	1.08	18.89	2	XXX
75966	TC	A	REPAIR ARTERIAL BLOCKAGE	0.00	15.81	0.99	16.80		XXX
75966	26	A	REPAIR ARTERIAL BLOCKAGE	1.38	0.62	0.09	2.09	2	XXX
75967		D	REPAIR ARTERIAL BLOCKAGE	0.00	0.00	0.00	0.00		XXX
75968		A	REPAIR ARTERY BLOCKAGE, EACH	0.37	8.59	0.55	9.51	2	XXX
75968	TC	A	REPAIR ARTERY BLOCKAGE, EACH	0.00	8.43	0.53	8.96		XXX
75968	26	A	REPAIR ARTERY BLOCKAGE, EACH	0.37	0.16	0.02	0.55	2	XXX
75969		D	REPAIR ARTERY BLOCKAGE, EACH	0.00	0.00	0.00	0.00		XXX
75970		A	TRANSCATHETER BIOPSY	0.87	11.98	0.79	13.64	2	XXX
75970	TC	A	TRANSCATHETER BIOPSY	0.00	11.59	0.73	12.32		XXX
75970	26	A	TRANSCATHETER BIOPSY	0.87	0.39	0.06	1.32	2	XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
75971		D	VASCULAR BIOPSY	0.00	0.00	0.00	0.00		XXX
75978		C	REPAIR VENOUS BLOCKAGE	0.00	0.00	0.00	0.00		XXX
75978	TC	C	REPAIR VENOUS BLOCKAGE	0.00	0.00	0.00	0.00		XXX
75978	26	A	REPAIR VENOUS BLOCKAGE	0.58	0.26	0.04	0.88	2	XXX
75979		D	REPAIR VENOUS BLOCKAGE	0.00	0.00	0.00	0.00		XXX
75980		A	CONTRAST XRAY EXAM BILE DUCT	1.52	6.12	0.44	8.08	2	XXX
75980	TC	A	CONTRAST XRAY EXAM BILE DUCT	0.00	5.44	0.34	5.78		XXX
75980	26	A	CONTRAST XRAY EXAM BILE DUCT	1.52	0.68	0.10	2.30	2	XXX
75981		D	CONTRAST XRAY EXAM BILE DUCT	0.00	0.00	0.00	0.00		XXX
75982		A	CONTRAST XRAY EXAM BILE DUCT	1.52	6.80	0.48	8.80	2	XXX
75982	TC	A	CONTRAST XRAY EXAM BILE DUCT	0.00	6.12	0.38	6.50		XXX
75982	26	A	CONTRAST XRAY EXAM BILE DUCT	1.52	0.68	0.10	2.30	2	XXX
75983		D	CONTRAST XRAY EXAM BILE DUCT	0.00	0.00	0.00	0.00		XXX
75984		A	XRAY CONTROL CATHETER CHANGE	0.76	2.29	0.17	3.22	2	XXX
75984	TC	A	XRAY CONTROL CATHETER CHANGE	0.00	1.95	0.12	2.07		XXX
75984	26	A	XRAY CONTROL CATHETER CHANGE	0.76	0.34	0.05	1.15	2	XXX
75985		D	XRAY CONTROL CATHETER CHANGE	0.00	0.00	0.00	0.00		XXX
75989		A	ABSCESS DRAINAGE UNDER X-RAY	1.26	3.72	0.28	5.26	2	XXX
75989	TC	A	ABSCESS DRAINAGE UNDER X-RAY	0.00	3.16	0.20	3.36		XXX
75989	26	A	ABSCESS DRAINAGE UNDER X-RAY	1.26	0.56	0.08	1.90	2	XXX
75990		D	ABSCESS DRAINAGE UNDER X-RAY	0.00	0.00	0.00	0.00		XXX
76000		A	FLUOROSCOPE EXAMINATION	0.17	1.38	0.09	1.64	2	XXX
76000	TC	A	FLUOROSCOPE EXAMINATION	0.00	1.31	0.08	1.39		XXX
76000	26	A	FLUOROSCOPE EXAMINATION	0.17	0.07	0.01	0.25	2	XXX
76001		A	FLUOROSCOPE EXAM, EXTENSIVE	0.71	2.95	0.22	3.88	2	XXX
76001	TC	A	FLUOROSCOPE EXAM, EXTENSIVE	0.00	2.63	0.17	2.80		XXX
76001	26	A	FLUOROSCOPE EXAM, EXTENSIVE	0.71	0.32	0.05	1.08	2	XXX
76003		A	NEEDLE LOCALIZATION BY X-RAY	0.58	1.57	0.12	2.27	2	XXX
76003	TC	A	NEEDLE LOCALIZATION BY X-RAY	0.00	1.31	0.08	1.39		XXX
76003	26	A	NEEDLE LOCALIZATION BY X-RAY	0.58	0.26	0.04	0.88	2	XXX
76010		A	X-RAY, NOSE TO RECTUM	0.19	0.61	0.04	0.84	2	XXX
76010	TC	A	X-RAY, NOSE TO RECTUM	0.00	0.53	0.03	0.56		XXX
76010	26	A	X-RAY, NOSE TO RECTUM	0.19	0.08	0.01	0.28	2	XXX
76020		A	X-RAYS FOR BONE AGE	0.20	0.62	0.04	0.86	2	XXX
76020	TC	A	X-RAYS FOR BONE AGE	0.00	0.53	0.03	0.56		XXX
76020	26	A	X-RAYS FOR BONE AGE	0.20	0.09	0.01	0.30	2	XXX
76040		A	X-RAYS, BONE EVALUATION	0.28	0.92	0.07	1.27	2	XXX
76040	TC	A	X-RAYS, BONE EVALUATION	0.00	0.79	0.05	0.84		XXX
76040	26	A	X-RAYS, BONE EVALUATION	0.28	0.13	0.02	0.43	2	XXX
76061		A	X-RAYS, BONE SURVEY	0.47	1.21	0.09	1.77	2	XXX
76061	TC	A	X-RAYS, BONE SURVEY	0.00	1.00	0.06	1.06		XXX
76061	26	A	X-RAYS, BONE SURVEY	0.47	0.21	0.03	0.71	2	XXX
76062		A	X-RAYS, BONE SURVEY	0.58	1.71	0.13	2.42	2	XXX
76062	TC	A	X-RAYS, BONE SURVEY	0.00	1.45	0.09	1.54		XXX
76062	26	A	X-RAYS, BONE SURVEY	0.58	0.26	0.04	0.88	2	XXX
76065		A	X-RAYS, BONE EVALUATION	0.29	0.87	0.07	1.23	2	XXX
76065	TC	A	X-RAYS, BONE EVALUATION	0.00	0.74	0.05	0.79		XXX
76065	26	A	X-RAYS, BONE EVALUATION	0.29	0.13	0.02	0.44	2	XXX
76066		A	JOINT(S) SURVEY, SINGLE FILM	0.32	1.25	0.09	1.66	2	XXX
76066	TC	A	JOINT(S) SURVEY, SINGLE FILM	0.00	1.11	0.07	1.18		XXX
76066	26	A	JOINT(S) SURVEY, SINGLE FILM	0.32	0.14	0.02	0.48	2	XXX
76070		A	CT SCAN, BONE DENSITY STUDY	0.26	3.08	0.21	3.55	2	XXX
76070	TC	A	CT SCAN, BONE DENSITY STUDY	0.00	2.96	0.19	3.15		XXX
76070	26	A	CT SCAN, BONE DENSITY STUDY	0.26	0.12	0.02	0.40	2	XXX
76080		A	X-RAY EXAM OF FISTULA	0.58	1.31	0.11	2.00	2	XXX
76080	TC	A	X-RAY EXAM OF FISTULA	0.00	1.05	0.07	1.12		XXX
76080	26	A	X-RAY EXAM OF FISTULA	0.58	0.26	0.04	0.88	2	XXX
76081		D	X-RAY EXAM OF FISTULA	0.00	0.00	0.00	0.00		XXX
76086		A	X-RAY OF MAMMARY DUCT	0.37	2.80	0.19	3.36	2	XXX
76086	TC	A	X-RAY OF MAMMARY DUCT	0.00	2.63	0.17	2.80		XXX
76086	26	A	X-RAY OF MAMMARY DUCT	0.37	0.17	0.02	0.56	2	XXX
76087		D	X-RAY OF MAMMARY DUCT	0.00	0.00	0.00	0.00		XXX
76088		A	X-RAY OF MAMMARY DUCTS	0.47	3.89	0.26	4.62	2	XXX
76088	TC	A	X-RAY OF MAMMARY DUCTS	0.00	3.68	0.23	3.91		XXX
76088	26	A	X-RAY OF MAMMARY DUCTS	0.47	0.21	0.03	0.71	2	XXX
76089		D	X-RAY OF MAMMARY DUCTS	0.00	0.00	0.00	0.00		XXX
76090		A	MAMMOGRAM, ONE BREAST	0.26	1.17	0.09	1.52	2	XXX
76090	TC	A	MAMMOGRAM, ONE BREAST	0.00	1.05	0.07	1.12		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
76090	26	A	MAMMOGRAM, ONE BREAST	0.26	0.12	0.02	0.40	2	XXX
76091		A	MAMMOGRAM, BOTH BREASTS	0.43	1.50	0.11	2.04	2	XXX
76091	TC	A	MAMMOGRAM, BOTH BREASTS	0.00	1.31	0.08	1.39		XXX
76091	26	A	MAMMOGRAM, BOTH BREASTS	0.43	0.19	0.03	0.65	2	XXX
76092		E	MAMMOGRAM, SCREENING	0.00	0.00	0.00	0.00		XXX
76096		A	X-RAY EXAM, BREAST NODULE	1.03	3.09	0.24	4.36	2	XXX
76096	TC	A	X-RAY EXAM, BREAST NODULE	0.00	2.63	0.17	2.80		XXX
76096	26	A	X-RAY EXAM, BREAST NODULE	1.03	0.46	0.07	1.56	2	XXX
76097		A	X-RAY EXAM, BREAST NODULE	0.59	1.31	0.11	2.01	2	XXX
76097	TC	A	X-RAY EXAM, BREAST NODULE	0.00	1.05	0.07	1.12		XXX
76097	26	A	X-RAY EXAM, BREAST NODULE	0.59	0.26	0.04	0.89	2	XXX
76098		A	X-RAY EXAM, BREAST SPECIMEN	0.16	0.49	0.04	0.69	2	XXX
76098	TC	A	X-RAY EXAM, BREAST SPECIMEN	0.00	0.42	0.03	0.45		XXX
76098	26	A	X-RAY EXAM, BREAST SPECIMEN	0.16	0.07	0.01	0.24	2	XXX
76100		A	X-RAY EXAM OF BODY SECTION	0.62	1.54	0.12	2.28	2	XXX
76100	TC	A	X-RAY EXAM OF BODY SECTION	0.00	1.26	0.08	1.34		XXX
76100	26	A	X-RAY EXAM OF BODY SECTION	0.62	0.28	0.04	0.94	2	XXX
76101		A	COMPLEX BODY SECTION X-RAY	0.62	1.70	0.13	2.45	2	XXX
76101	TC	A	COMPLEX BODY SECTION X-RAY	0.00	1.42	0.09	1.51		XXX
76101	26	A	COMPLEX BODY SECTION X-RAY	0.62	0.28	0.04	0.94	2	XXX
76102		A	COMPLEX BODY SECTION X-RAYS	0.62	2.02	0.15	2.79	2	XXX
76102	TC	A	COMPLEX BODY SECTION X-RAYS	0.00	1.74	0.11	1.85		XXX
76102	26	A	COMPLEX BODY SECTION X-RAYS	0.62	0.28	0.04	0.94	2	XXX
76120		A	CINEMATIC X-RAYS	0.40	1.23	0.10	1.73	2	XXX
76120	TC	A	CINEMATIC X-RAYS	0.00	1.05	0.07	1.12		XXX
76120	26	A	CINEMATIC X-RAYS	0.40	0.18	0.03	0.61	2	XXX
76125		A	CINEMATIC X-RAYS	0.28	0.91	0.07	1.26	2	XXX
76125	TC	A	CINEMATIC X-RAYS	0.00	0.79	0.05	0.84		XXX
76125	26	A	CINEMATIC X-RAYS	0.28	0.12	0.02	0.42	2	XXX
76140		X	X-RAY CONSULTATION	0.00	0.00	0.00	0.00		XXX
76150		A	X-RAY EXAM, DRY PROCESS	0.00	0.42	0.03	0.45		XXX
76350		C	SPECIAL X-RAY CONTRAST STUDY	0.00	0.00	0.00	0.00		XXX
76355		A	CAT SCAN FOR LOCALIZATION	1.28	8.86	0.60	10.74	2	XXX
76355	TC	A	CAT SCAN FOR LOCALIZATION	0.00	8.29	0.52	8.81		XXX
76355	26	A	CAT SCAN FOR LOCALIZATION	1.28	0.57	0.08	1.93	2	XXX
76360		A	CAT SCAN FOR NEEDLE BIOPSY	1.22	8.83	0.60	10.65	2	XXX
76360	TC	A	CAT SCAN FOR NEEDLE BIOPSY	0.00	8.29	0.52	8.81		XXX
76360	26	A	CAT SCAN FOR NEEDLE BIOPSY	1.22	0.54	0.08	1.84	2	XXX
76361		D	CAT SCAN FOR NEEDLE BIOPSY	0.00	0.00	0.00	0.00		XXX
76365		A	CAT SCAN FOR CYST ASPIRATION	1.22	8.83	0.60	10.65	2	XXX
76365	TC	A	CAT SCAN FOR CYST ASPIRATION	0.00	8.29	0.52	8.81		XXX
76365	26	A	CAT SCAN FOR CYST ASPIRATION	1.22	0.54	0.08	1.84	2	XXX
76366		D	CAT SCAN FOR CYST ASPIRATION	0.00	0.00	0.00	0.00		XXX
76370		A	CAT SCAN FOR THERAPY GUIDE	0.90	3.36	0.25	4.51	2	XXX
76370	TC	A	CAT SCAN FOR THERAPY GUIDE	0.00	2.96	0.19	3.15		XXX
76370	26	A	CAT SCAN FOR THERAPY GUIDE	0.90	0.40	0.06	1.36	2	XXX
76375		A	CAT SCANS, OTHER PLANES	0.16	3.62	0.23	4.01	2	XXX
76375	TC	A	CAT SCANS, OTHER PLANES	0.00	3.55	0.22	3.77		XXX
76375	26	A	CAT SCANS, OTHER PLANES	0.16	0.07	0.01	0.24	2	XXX
76380		A	CAT SCAN FOLLOW-UP STUDY	1.03	3.98	0.29	5.30	2	XXX
76380	TC	A	CAT SCAN FOLLOW-UP STUDY	0.00	3.52	0.22	3.74		XXX
76380	26	A	CAT SCAN FOLLOW-UP STUDY	1.03	0.46	0.07	1.56	2	XXX
76400		A	MAGNETIC IMAGE, BONE MARROW	1.69	12.01	0.82	14.52	2	XXX
76400	TC	A	MAGNETIC IMAGE, BONE MARROW	0.00	11.25	0.71	11.96		XXX
76400	26	A	MAGNETIC IMAGE, BONE MARROW	1.69	0.76	0.11	2.56	2	XXX
76499		C	RADIOGRAPHIC PROCEDURE	0.00	0.00	0.00	0.00		XXX
76506		A	ECHO EXAM OF HEAD	0.67	1.72	0.13	2.52	2	XXX
76506	TC	A	ECHO EXAM OF HEAD	0.00	1.42	0.09	1.51		XXX
76506	26	A	ECHO EXAM OF HEAD	0.67	0.30	0.04	1.01	2	XXX
76511		A	ECHO EXAM OF EYE	0.58	1.52	0.12	2.22	2	XXX
76511	TC	A	ECHO EXAM OF EYE	0.00	1.26	0.08	1.34		XXX
76511	26	A	ECHO EXAM OF EYE	0.58	0.26	0.04	0.88	2	XXX
76512		A	ECHO EXAM OF EYE	0.70	1.84	0.15	2.69	2	XXX
76512	TC	A	ECHO EXAM OF EYE	0.00	1.53	0.10	1.63		XXX
76512	26	A	ECHO EXAM OF EYE	0.70	0.31	0.05	1.06	2	XXX
76513		A	ECHO EXAM OF EYE, WATER BATH	0.70	1.84	0.15	2.69	2	XXX
76513	TC	A	ECHO EXAM OF EYE, WATER BATH	0.00	1.53	0.10	1.63		XXX
76513	26	A	ECHO EXAM OF EYE, WATER BATH	0.70	0.31	0.05	1.06	2	XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
76516		A	ECHO EXAM OF EYE	0.58	1.52	0.12	2.22	2	XXX
76516	TC	A	ECHO EXAM OF EYE	0.00	1.26	0.08	1.34		XXX
76516	26	A	ECHO EXAM OF EYE	0.58	0.26	0.04	0.88	2	XXX
76519		A	ECHO EXAM OF EYE	0.58	1.52	0.12	2.22	2	XXX
76519	TC	A	ECHO EXAM OF EYE	0.00	1.26	0.08	1.34		XXX
76519	26	A	ECHO EXAM OF EYE	0.58	0.26	0.04	0.88	2	XXX
76529		A	ECHO EXAM OF EYE	0.61	1.64	0.13	2.38	2	XXX
76529	TC	A	ECHO EXAM OF EYE	0.00	1.37	0.09	1.46		XXX
76529	26	A	ECHO EXAM OF EYE	0.61	0.27	0.04	0.92	2	XXX
76536		A	ECHO EXAM OF HEAD AND NECK	0.60	1.69	0.13	2.42	2	XXX
76536	TC	A	ECHO EXAM OF HEAD AND NECK	0.00	1.42	0.09	1.51		XXX
76536	26	A	ECHO EXAM OF HEAD AND NECK	0.60	0.27	0.04	0.91	2	XXX
76604		A	ECHO EXAM OF CHEST	0.59	1.58	0.12	2.29	2	XXX
76604	TC	A	ECHO EXAM OF CHEST	0.00	1.31	0.08	1.39		XXX
76604	26	A	ECHO EXAM OF CHEST	0.59	0.27	0.04	0.90	2	XXX
76645		A	ECHO EXAM OF BREAST	0.58	1.31	0.11	2.00	2	XXX
76645	TC	A	ECHO EXAM OF BREAST	0.00	1.05	0.07	1.12		XXX
76645	26	A	ECHO EXAM OF BREAST	0.58	0.26	0.04	0.88	2	XXX
76700		A	ECHO EXAM OF ABDOMEN	0.85	2.35	0.17	3.37	2	XXX
76700	TC	A	ECHO EXAM OF ABDOMEN	0.00	1.97	0.12	2.09		XXX
76700	26	A	ECHO EXAM OF ABDOMEN	0.85	0.38	0.05	1.28	2	XXX
76705		A	ECHO EXAM OF ABDOMEN	0.63	1.70	0.13	2.46	2	XXX
76705	TC	A	ECHO EXAM OF ABDOMEN	0.00	1.42	0.09	1.51		XXX
76705	26	A	ECHO EXAM OF ABDOMEN	0.63	0.28	0.04	0.95	2	XXX
76770		A	ECHO EXAM ABDOMEN BACK WALL	0.78	2.32	0.17	3.27	2	XXX
76770	TC	A	ECHO EXAM ABDOMEN BACK WALL	0.00	1.97	0.12	2.09		XXX
76770	26	A	ECHO EXAM ABDOMEN BACK WALL	0.78	0.35	0.05	1.18	2	XXX
76775		A	ECHO EXAM ABDOMEN BACK WALL	0.62	1.70	0.13	2.45	2	XXX
76775	TC	A	ECHO EXAM ABDOMEN BACK WALL	0.00	1.42	0.09	1.51		XXX
76775	26	A	ECHO EXAM ABDOMEN BACK WALL	0.62	0.28	0.04	0.94	2	XXX
76778		A	ECHO EXAM KIDNEY TRANSPLANT	0.78	2.32	0.17	3.27	2	XXX
76778	TC	A	ECHO EXAM KIDNEY TRANSPLANT	0.00	1.97	0.12	2.09		XXX
76778	26	A	ECHO EXAM KIDNEY TRANSPLANT	0.78	0.35	0.05	1.18	2	XXX
76800		A	ECHO EXAM SPINAL CANAL	1.19	1.95	0.17	3.31	2	XXX
76800	TC	A	ECHO EXAM SPINAL CANAL	0.00	1.42	0.09	1.51		XXX
76800	26	A	ECHO EXAM SPINAL CANAL	1.19	0.53	0.08	1.80	2	XXX
76805		A	ECHO EXAM OF PREGNANT UTERUS	1.04	2.58	0.20	3.82	2	XXX
76805	TC	A	ECHO EXAM OF PREGNANT UTERUS	0.00	2.11	0.13	2.24		XXX
76805	26	A	ECHO EXAM OF PREGNANT UTERUS	1.04	0.47	0.07	1.58	2	XXX
76810		A	ECHO EXAM OF PREGNANT UTERUS	2.08	5.14	0.39	7.61	2	XXX
76810	TC	A	ECHO EXAM OF PREGNANT UTERUS	0.00	4.21	0.26	4.47		XXX
76810	26	A	ECHO EXAM OF PREGNANT UTERUS	2.08	0.93	0.13	3.14	2	XXX
76815		A	ECHO EXAM OF PREGNANT UTERUS	0.69	1.73	0.13	2.55	2	XXX
76815	TC	A	ECHO EXAM OF PREGNANT UTERUS	0.00	1.42	0.09	1.51		XXX
76815	26	A	ECHO EXAM OF PREGNANT UTERUS	0.69	0.31	0.04	1.04	2	XXX
76816		A	ECHO EXAM FOLLOWUP OR REPEAT	0.61	1.38	0.11	2.10	2	XXX
76816	TC	A	ECHO EXAM FOLLOWUP OR REPEAT	0.00	1.11	0.07	1.18		XXX
76816	26	A	ECHO EXAM FOLLOWUP OR REPEAT	0.61	0.27	0.04	0.92	2	XXX
76818		A	FETAL BIOPHYSICAL PROFILE	0.81	1.99	0.15	2.95	2	XXX
76818	TC	A	FETAL BIOPHYSICAL PROFILE	0.00	1.63	0.10	1.73		XXX
76818	26	A	FETAL BIOPHYSICAL PROFILE	0.81	0.36	0.05	1.22	2	XXX
76825		A	ECHO EXAM OF FETAL HEART	0.80	2.33	0.17	3.30	2	XXX
76825	TC	A	ECHO EXAM OF FETAL HEART	0.00	1.97	0.12	2.09		XXX
76825	26	A	ECHO EXAM OF FETAL HEART	0.80	0.36	0.05	1.21	2	XXX
76830		A	ECHO EXAM, TRANSVAGINAL	0.73	1.86	0.15	2.74	2	XXX
76830	TC	A	ECHO EXAM, TRANSVAGINAL	0.00	1.53	0.10	1.63		XXX
76830	26	A	ECHO EXAM, TRANSVAGINAL	0.73	0.33	0.05	1.11	2	XXX
76855		D	ECHO EXAM OF PELVIS	0.00	0.00	0.00	0.00		XXX
76856		A	ECHO EXAM OF PELVIS	0.73	1.86	0.15	2.74	2	XXX
76856	TC	A	ECHO EXAM OF PELVIS	0.00	1.53	0.10	1.63		XXX
76856	26	A	ECHO EXAM OF PELVIS	0.73	0.33	0.05	1.11	2	XXX
76857		A	ECHO EXAM OF PELVIS	0.39	1.22	0.10	1.71	2	XXX
76857	TC	A	ECHO EXAM OF PELVIS	0.00	1.05	0.07	1.12		XXX
76857	26	A	ECHO EXAM OF PELVIS	0.39	0.17	0.03	0.59	2	XXX
76870		A	ECHO EXAM OF SCROTUM	0.68	1.83	0.14	2.65	2	XXX
76870	TC	A	ECHO EXAM OF SCROTUM	0.00	1.53	0.10	1.63		XXX
76870	26	A	ECHO EXAM OF SCROTUM	0.68	0.30	0.04	1.02	2	XXX
76872		A	ECHO EXAM OF PROSTATE	0.73	1.86	0.15	2.74	2	XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
76872	TC	A	ECHO EXAM OF PROSTATE	0.00	1.53	0.10	1.63		XXX
76872	26	A	ECHO EXAM OF PROSTATE	0.73	0.33	0.05	1.11	2	XXX
76880		A	ECHO EXAM OF EXTREMITY	0.63	1.70	0.13	2.46	2	XXX
76880	TC	A	ECHO EXAM OF EXTREMITY	0.00	1.42	0.09	1.51		XXX
76880	26	A	ECHO EXAM OF EXTREMITY	0.63	0.28	0.04	0.95	2	XXX
76925		D	ECHO EXAM OF BLOOD FLOW	0.00	0.00	0.00	0.00		XXX
76926		D	ECHO EXAM OF HEAD & TRUNK	0.00	0.00	0.00	0.00		XXX
76930		A	ECHO GUIDE FOR HEART SAC TAP	0.71	1.85	0.15	2.71	2	XXX
76930	TC	A	ECHO GUIDE FOR HEART SAC TAP	0.00	1.53	0.10	1.63		XXX
76930	26	A	ECHO GUIDE FOR HEART SAC TAP	0.71	0.32	0.05	1.08	2	XXX
76931		D	ECHO GUIDE FOR HEART SAC TAP	0.00	0.00	0.00	0.00		XXX
76932		A	ECHO GUIDE FOR HEART BIOPSY	0.71	1.85	0.15	2.71	2	XXX
76932	TC	A	ECHO GUIDE FOR HEART BIOPSY	0.00	1.53	0.10	1.63		XXX
76932	26	A	ECHO GUIDE FOR HEART BIOPSY	0.71	0.32	0.05	1.08	2	XXX
76933		D	ECHO GUIDE FOR HEART BIOPSY	0.00	0.00	0.00	0.00		XXX
76934		A	ECHO GUIDE FOR CHEST TAP	0.71	1.85	0.15	2.71	2	XXX
76934	TC	A	ECHO GUIDE FOR CHEST TAP	0.00	1.53	0.10	1.63		XXX
76934	26	A	ECHO GUIDE FOR CHEST TAP	0.71	0.32	0.05	1.08	2	XXX
76935		D	ECHO GUIDE FOR CHEST TAP	0.00	0.00	0.00	0.00		XXX
76938		A	ECHO EXAM FOR DRAINAGE	0.71	1.85	0.15	2.71	2	XXX
76938	TC	A	ECHO EXAM FOR DRAINAGE	0.00	1.53	0.10	1.63		XXX
76938	26	A	ECHO EXAM FOR DRAINAGE	0.71	0.32	0.05	1.08	2	XXX
76939		D	ECHO EXAM FOR DRAINAGE	0.00	0.00	0.00	0.00		XXX
76942		A	ECHO GUIDE FOR BIOPSY	0.71	1.85	0.15	2.71	2	XXX
76942	TC	A	ECHO GUIDE FOR BIOPSY	0.00	1.53	0.10	1.63		XXX
76942	26	A	ECHO GUIDE FOR BIOPSY	0.71	0.32	0.05	1.08	2	XXX
76943		D	ECHO GUIDE FOR BIOPSY	0.00	0.00	0.00	0.00		XXX
76946		A	ECHO GUIDE FOR AMNIOCENTESIS	0.39	1.70	0.13	2.22	2	XXX
76946	TC	A	ECHO GUIDE FOR AMNIOCENTESIS	0.00	1.53	0.10	1.63		XXX
76946	26	A	ECHO GUIDE FOR AMNIOCENTESIS	0.39	0.17	0.03	0.59	2	XXX
76947		D	ECHO GUIDE FOR AMNIOCENTESIS	0.00	0.00	0.00	0.00		XXX
76948		A	ECHO GUIDE, OVA ASPIRATION	0.39	1.70	0.13	2.22	2	XXX
76948	TC	A	ECHO GUIDE, OVA ASPIRATION	0.00	1.53	0.10	1.63		XXX
76948	26	A	ECHO GUIDE, OVA ASPIRATION	0.39	0.17	0.03	0.59	2	XXX
76949		D	ECHO GUIDE, OVA ASPIRATION	0.00	0.00	0.00	0.00		XXX
76950		A	ECHO GUIDANCE RADIOTHERAPY	0.62	1.59	0.12	2.33	2	XXX
76950	TC	A	ECHO GUIDANCE RADIOTHERAPY	0.00	1.31	0.08	1.39		XXX
76950	26	A	ECHO GUIDANCE RADIOTHERAPY	0.62	0.28	0.04	0.94	2	XXX
76960		A	ECHO GUIDANCE RADIOTHERAPY	0.62	1.59	0.12	2.33	2	XXX
76960	TC	A	ECHO GUIDANCE RADIOTHERAPY	0.00	1.31	0.08	1.39		XXX
76960	26	A	ECHO GUIDANCE RADIOTHERAPY	0.62	0.28	0.04	0.94	2	XXX
76970		A	ULTRASOUND EXAM FOLLOW-UP	0.42	1.24	0.10	1.76	2	XXX
76970	TC	A	ULTRASOUND EXAM FOLLOW-UP	0.00	1.05	0.07	1.12		XXX
76970	26	A	ULTRASOUND EXAM FOLLOW-UP	0.42	0.19	0.03	0.64	2	XXX
76986		A	ECHO EXAM AT SURGERY	1.27	3.20	0.25	4.72	2	XXX
76986	TC	A	ECHO EXAM AT SURGERY	0.00	2.63	0.17	2.80		XXX
76986	26	A	ECHO EXAM AT SURGERY	1.27	0.57	0.08	1.92	2	XXX
76999		C	ECHO EXAMINATION PROCEDURE	0.00	0.00	0.00	0.00		XXX
77261		A	RADIATION THERAPY PLANNING	1.47	0.66	0.09	2.22	2	XXX
77262		A	RADIATION THERAPY PLANNING	2.22	0.99	0.14	3.35	2	XXX
77263		A	RADIATION THERAPY PLANNING	3.30	1.48	0.21	4.99	2	XXX
77280		A	SET RADIATION THERAPY FIELD	0.74	3.82	0.27	4.83	2	XXX
77280	TC	A	SET RADIATION THERAPY FIELD	0.00	3.49	0.22	3.71		XXX
77280	26	A	SET RADIATION THERAPY FIELD	0.74	0.33	0.05	1.12	2	XXX
77285		A	SET RADIATION THERAPY FIELD	1.10	6.09	0.42	7.61	2	XXX
77285	TC	A	SET RADIATION THERAPY FIELD	0.00	5.60	0.35	5.95		XXX
77285	26	A	SET RADIATION THERAPY FIELD	1.10	0.49	0.07	1.66	2	XXX
77290		A	SET RADIATION THERAPY FIELD	1.65	7.27	0.52	9.44	2	XXX
77290	TC	A	SET RADIATION THERAPY FIELD	0.00	6.53	0.41	6.94		XXX
77290	26	A	SET RADIATION THERAPY FIELD	1.65	0.74	0.11	2.50	2	XXX
77299		C	RADIATION THERAPY PLANNING	0.00	0.00	0.00	0.00		XXX
77300		A	RADIATION THERAPY DOSE PLAN	0.66	1.64	0.12	2.42	2	XXX
77300	TC	A	RADIATION THERAPY DOSE PLAN	0.00	1.35	0.08	1.43		XXX
77300	26	A	RADIATION THERAPY DOSE PLAN	0.66	0.29	0.04	0.99	2	XXX
77305		A	RADIATION THERAPY DOSE PLAN	0.74	2.19	0.17	3.10	2	XXX
77305	TC	A	RADIATION THERAPY DOSE PLAN	0.00	1.86	0.12	1.98		XXX
77305	26	A	RADIATION THERAPY DOSE PLAN	0.74	0.33	0.05	1.12	2	XXX
77310		A	RADIATION THERAPY DOSE PLAN	1.10	2.82	0.22	4.14	2	XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
77310	TC	A	RADIATION THERAPY DOSE PLAN	0.00	2.33	0.15	2.48		XXX
77310	26	A	RADIATION THERAPY DOSE PLAN	1.10	0.49	0.07	1.66	2	XXX
77315	A	A	RADIATION THERAPY DOSE PLAN	1.65	3.40	0.28	5.33	2	XXX
77315	TC	A	RADIATION THERAPY DOSE PLAN	0.00	2.66	0.17	2.83		XXX
77315	26	A	RADIATION THERAPY DOSE PLAN	1.65	0.74	0.11	2.50	2	XXX
77321	A	A	RADIATION THERAPY PORT PLAN	1.00	4.50	0.31	5.81	2	XXX
77321	TC	A	RADIATION THERAPY PORT PLAN	0.00	4.05	0.25	4.30		XXX
77321	26	A	RADIATION THERAPY PORT PLAN	1.00	0.45	0.06	1.51	2	XXX
77326	A	A	RADIATION THERAPY DOSE PLAN	0.98	2.82	0.21	4.01	2	XXX
77326	TC	A	RADIATION THERAPY DOSE PLAN	0.00	2.38	0.15	2.53		XXX
77326	26	A	RADIATION THERAPY DOSE PLAN	0.98	0.44	0.06	1.48	2	XXX
77327	A	A	RADIATION THERAPY DOSE PLAN	1.47	4.15	0.31	5.93	2	XXX
77327	TC	A	RADIATION THERAPY DOSE PLAN	0.00	3.49	0.22	3.71		XXX
77327	26	A	RADIATION THERAPY DOSE PLAN	1.47	0.66	0.09	2.22	2	XXX
77328	A	A	RADIATION THERAPY DOSE PLAN	2.20	5.96	0.45	8.61	2	XXX
77328	TC	A	RADIATION THERAPY DOSE PLAN	0.00	4.98	0.31	5.29		XXX
77328	26	A	RADIATION THERAPY DOSE PLAN	2.20	0.98	0.14	3.32	2	XXX
77331	A	A	SPECIAL RADIATION DOSIMETRY	0.92	0.92	0.09	1.93	2	XXX
77331	TC	A	SPECIAL RADIATION DOSIMETRY	0.00	0.51	0.03	0.54		XXX
77331	26	A	SPECIAL RADIATION DOSIMETRY	0.92	0.41	0.06	1.39	2	XXX
77332	A	A	RADIATION TREATMENT AID(S)	0.58	1.61	0.12	2.31	2	XXX
77332	TC	A	RADIATION TREATMENT AID(S)	0.00	1.35	0.08	1.43		XXX
77332	26	A	RADIATION TREATMENT AID(S)	0.58	0.26	0.04	0.88	2	XXX
77333	A	A	RADIATION TREATMENT AID(S)	0.88	2.29	0.18	3.35	2	XXX
77333	TC	A	RADIATION TREATMENT AID(S)	0.00	1.90	0.12	2.02		XXX
77333	26	A	RADIATION TREATMENT AID(S)	0.88	0.39	0.06	1.33	2	XXX
77334	A	A	RADIATION TREATMENT AID(S)	1.31	3.84	0.28	5.43	2	XXX
77334	TC	A	RADIATION TREATMENT AID(S)	0.00	3.26	0.20	3.46		XXX
77334	26	A	RADIATION TREATMENT AID(S)	1.31	0.58	0.08	1.97	2	XXX
77336	A	A	RADIATION PHYSICS CONSULT	0.00	2.99	0.19	3.18		XXX
77370	A	A	RADIATION PHYSICS CONSULT	0.00	3.51	0.22	3.73		XXX
77399	C	A	EXTERNAL RADIATION DOSIMETRY	0.00	0.00	0.00	0.00		XXX
77401	A	A	RADIATION TREATMENT DELIVERY	0.00	1.78	0.11	1.89		XXX
77402	A	A	RADIATION TREATMENT DELIVERY	0.00	1.78	0.11	1.89		XXX
77403	A	A	RADIATION TREATMENT DELIVERY	0.00	1.78	0.11	1.89		XXX
77404	A	A	RADIATION TREATMENT DELIVERY	0.00	1.78	0.11	1.89		XXX
77406	A	A	RADIATION TREATMENT DELIVERY	0.00	1.78	0.11	1.89		XXX
77407	A	A	RADIATION TREATMENT DELIVERY	0.00	2.10	0.13	2.23		XXX
77408	A	A	RADIATION TREATMENT DELIVERY	0.00	2.10	0.13	2.23		XXX
77409	A	A	RADIATION TREATMENT DELIVERY	0.00	2.10	0.13	2.23		XXX
77411	A	A	RADIATION TREATMENT DELIVERY	0.00	2.10	0.13	2.23		XXX
77412	A	A	RADIATION TREATMENT DELIVERY	0.00	2.33	0.15	2.48		XXX
77413	A	A	RADIATION TREATMENT DELIVERY	0.00	2.33	0.15	2.48		XXX
77414	A	A	RADIATION TREATMENT DELIVERY	0.00	2.33	0.15	2.48		XXX
77416	A	A	RADIATION TREATMENT DELIVERY	0.00	2.33	0.15	2.48		XXX
77417	A	A	RADIOLOGY PORT FILM(S)	0.00	0.60	0.04	0.64		XXX
77420	A	A	WEEKLY RADIATION THERAPY	1.70	0.76	0.11	2.57	2	XXX
77425	A	A	WEEKLY RADIATION THERAPY	2.57	1.15	0.17	3.89	2	XXX
77430	A	A	WEEKLY RADIATION THERAPY	3.80	1.70	0.24	5.74	2	XXX
77431	A	A	RADIATION THERAPY MANAGEMENT	1.90	0.85	0.12	2.87	2	XXX
77470	A	A	SPECIAL RADIATION TREATMENT	2.20	12.17	0.84	15.21	2	XXX
77470	TC	A	SPECIAL RADIATION TREATMENT	0.00	11.19	0.70	11.89		XXX
77470	26	A	SPECIAL RADIATION TREATMENT	2.20	0.98	0.14	3.32	2	XXX
77499	C	A	RADIATION THERAPY MANAGEMENT	0.00	0.00	0.00	0.00		XXX
77600	A	A	HYPERTHERMIA TREATMENT	1.65	3.80	0.30	5.75	2	XXX
77600	TC	A	HYPERTHERMIA TREATMENT	0.00	3.06	0.19	3.25		XXX
77600	26	A	HYPERTHERMIA TREATMENT	1.65	0.74	0.11	2.50	2	XXX
77605	A	A	HYPERTHERMIA TREATMENT	2.20	5.05	0.40	7.65	2	XXX
77605	TC	A	HYPERTHERMIA TREATMENT	0.00	4.07	0.26	4.33		XXX
77605	26	A	HYPERTHERMIA TREATMENT	2.20	0.98	0.14	3.32	2	XXX
77610	A	A	HYPERTHERMIA TREATMENT	1.65	3.80	0.30	5.75	2	XXX
77610	TC	A	HYPERTHERMIA TREATMENT	0.00	3.06	0.19	3.25		XXX
77610	26	A	HYPERTHERMIA TREATMENT	1.65	0.74	0.11	2.50	2	XXX
77615	A	A	HYPERTHERMIA TREATMENT	2.20	5.05	0.40	7.65	2	XXX
77615	TC	A	HYPERTHERMIA TREATMENT	0.00	4.07	0.26	4.33		XXX
77615	26	A	HYPERTHERMIA TREATMENT	2.20	0.98	0.14	3.32	2	XXX
77620	A	A	HYPERTHERMIA TREATMENT	1.65	3.80	0.30	5.75	2	XXX
77620	TC	A	HYPERTHERMIA TREATMENT	0.00	3.06	0.19	3.25		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
77620	26	A	HYPERTHERMIA TREATMENT	1.65	0.74	0.11	2.50	2	XXX
77750		A	INFUSE RADIOACTIVE MATERIALS	4.83	3.50	0.39	8.72	2	XXX
77750	TC	A	INFUSE RADIOACTIVE MATERIALS	0.00	1.34	0.08	1.42		XXX
77750	26	A	INFUSE RADIOACTIVE MATERIALS	4.83	2.16	0.31	7.30	2	XXX
77761		A	RADIOELEMENT APPLICATION	3.75	4.20	0.40	8.35	2	XXX
77761	TC	A	RADIOELEMENT APPLICATION	0.00	2.52	0.16	2.68		XXX
77761	26	A	RADIOELEMENT APPLICATION	3.75	1.68	0.24	5.67	2	XXX
77762		A	RADIOELEMENT APPLICATION	5.64	6.15	0.59	12.38	2	XXX
77762	TC	A	RADIOELEMENT APPLICATION	0.00	3.63	0.23	3.86		XXX
77762	26	A	RADIOELEMENT APPLICATION	5.64	2.52	0.36	8.52	2	XXX
77763		A	RADIOELEMENT APPLICATION	8.44	8.30	0.82	17.56	2	XXX
77763	TC	A	RADIOELEMENT APPLICATION	0.00	4.52	0.28	4.80		XXX
77763	26	A	RADIOELEMENT APPLICATION	8.44	3.78	0.54	12.76	2	XXX
77776		A	RADIOELEMENT APPLICATION	4.91	4.38	0.46	9.75	2	XXX
77776	TC	A	RADIOELEMENT APPLICATION	0.00	2.18	0.14	2.32		XXX
77776	26	A	RADIOELEMENT APPLICATION	4.91	2.20	0.32	7.43	2	XXX
77777		A	RADIOELEMENT APPLICATION	7.36	7.54	0.74	15.64	2	XXX
77777	TC	A	RADIOELEMENT APPLICATION	0.00	4.25	0.27	4.52		XXX
77777	26	A	RADIOELEMENT APPLICATION	7.36	3.29	0.47	11.12	2	XXX
77778		A	RADIOELEMENT APPLICATION	0.42	10.08	1.03	11.53	2	XXX
77778	TC	A	RADIOELEMENT APPLICATION	0.00	5.14	0.32	5.46		XXX
77778	26	A	RADIOELEMENT APPLICATION	0.42	4.94	0.71	6.07	2	XXX
77781		A	HIGH INTENSITY BRACHYTHERAPY	1.64	21.13	1.39	24.16	2	XXX
77781	TC	A	HIGH INTENSITY BRACHYTHERAPY	0.00	20.40	1.28	21.68		XXX
77781	26	A	HIGH INTENSITY BRACHYTHERAPY	1.64	0.73	0.11	2.48	2	XXX
77782		A	HIGH INTENSITY BRACHYTHERAPY	2.46	21.50	1.44	25.40	2	XXX
77782	TC	A	HIGH INTENSITY BRACHYTHERAPY	0.00	20.40	1.28	21.68		XXX
77782	26	A	HIGH INTENSITY BRACHYTHERAPY	2.46	1.10	0.16	3.72	2	XXX
77783		A	HIGH INTENSITY BRACHYTHERAPY	3.68	22.04	1.52	27.24	2	XXX
77783	TC	A	HIGH INTENSITY BRACHYTHERAPY	0.00	20.40	1.28	21.68		XXX
77783	26	A	HIGH INTENSITY BRACHYTHERAPY	3.68	1.64	0.24	5.56	2	XXX
77784		A	HIGH INTENSITY BRACHYTHERAPY	5.52	22.87	1.64	30.03	2	XXX
77784	TC	A	HIGH INTENSITY BRACHYTHERAPY	0.00	20.40	1.28	21.68		XXX
77784	26	A	HIGH INTENSITY BRACHYTHERAPY	5.52	2.47	0.36	8.35	2	XXX
77789		A	RADIOELEMENT APPLICATION	1.10	0.94	0.10	2.14	2	XXX
77789	TC	A	RADIOELEMENT APPLICATION	0.00	0.45	0.03	0.48		XXX
77789	26	A	RADIOELEMENT APPLICATION	1.10	0.49	0.07	1.66	2	XXX
77790		A	RADIOELEMENT HANDLING	1.10	1.00	0.10	2.20	2	XXX
77790	TC	A	RADIOELEMENT HANDLING	0.00	0.51	0.03	0.54		XXX
77790	26	A	RADIOELEMENT HANDLING	1.10	0.49	0.07	1.66	2	XXX
77799		C	RADIUM/RADIOISOTOPE THERAPY	0.00	0.00	0.00	0.00		XXX
78000		A	NUCLEAR EXAM OF THYROID	0.20	1.06	0.07	1.33	2	XXX
78000	TC	A	NUCLEAR EXAM OF THYROID	0.00	0.97	0.06	1.03		XXX
78000	26	A	NUCLEAR EXAM OF THYROID	0.20	0.09	0.01	0.30	2	XXX
78001		A	NUCLEAR EXAMS OF THYROID	0.27	1.43	0.10	1.80	2	XXX
78001	TC	A	NUCLEAR EXAMS OF THYROID	0.00	1.31	0.08	1.39		XXX
78001	26	A	NUCLEAR EXAMS OF THYROID	0.27	0.12	0.02	0.41	2	XXX
78003		A	SPECIAL THYROID NUCLEAR EXAM	0.34	1.12	0.08	1.54	2	XXX
78003	TC	A	SPECIAL THYROID NUCLEAR EXAM	0.00	0.97	0.06	1.03		XXX
78003	26	A	SPECIAL THYROID NUCLEAR EXAM	0.34	0.15	0.02	0.51	2	XXX
78006		A	THYROID IMAGING, WITH UPTAKE	0.52	2.63	0.18	3.33	2	XXX
78006	TC	A	THYROID IMAGING, WITH UPTAKE	0.00	2.40	0.15	2.55		XXX
78006	26	A	THYROID IMAGING, WITH UPTAKE	0.52	0.23	0.03	0.78	2	XXX
78007		A	THYROID IMAGING, WITH UPTAKE	0.54	2.82	0.19	3.55	2	XXX
78007	TC	A	THYROID IMAGING, WITH UPTAKE	0.00	2.58	0.16	2.74		XXX
78007	26	A	THYROID IMAGING, WITH UPTAKE	0.54	0.24	0.03	0.81	2	XXX
78010		A	NUCLEAR SCAN OF THYROID	0.41	2.00	0.14	2.55	2	XXX
78010	TC	A	NUCLEAR SCAN OF THYROID	0.00	1.82	0.11	1.93		XXX
78010	26	A	NUCLEAR SCAN OF THYROID	0.41	0.18	0.03	0.62	2	XXX
78011		A	NUCLEAR SCAN, THYROID FLOW	0.48	2.64	0.18	3.30	2	XXX
78011	TC	A	NUCLEAR SCAN, THYROID FLOW	0.00	2.42	0.15	2.57		XXX
78011	26	A	NUCLEAR SCAN, THYROID FLOW	0.48	0.22	0.03	0.73	2	XXX
78015		A	NUCLEAR SCAN OF THYROID	0.71	2.90	0.21	3.82	2	XXX
78015	TC	A	NUCLEAR SCAN OF THYROID	0.00	2.58	0.16	2.74		XXX
78015	26	A	NUCLEAR SCAN OF THYROID	0.71	0.32	0.05	1.08	2	XXX
78016		A	EXTENSIVE THYROID SCAN	0.86	3.89	0.28	5.03	2	XXX
78016	TC	A	EXTENSIVE THYROID SCAN	0.00	3.50	0.22	3.72		XXX
78016	26	A	EXTENSIVE THYROID SCAN	0.86	0.39	0.06	1.31	2	XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
78017		A	MULTIPLE NUCLEAR SCANS	0.92	4.15	0.29	5.36	2	XXX
78017	TC	A	MULTIPLE NUCLEAR SCANS	0.00	3.74	0.23	3.97		XXX
78017	26	A	MULTIPLE NUCLEAR SCANS	0.92	0.41	0.06	1.39	2	XXX
78018		A	WHOLE BODY NUCLEAR SCANS	1.00	5.90	0.40	7.30	2	XXX
78018	TC	A	WHOLE BODY NUCLEAR SCANS	0.00	5.45	0.34	5.79		XXX
78018	26	A	WHOLE BODY NUCLEAR SCANS	1.00	0.45	0.06	1.51	2	XXX
78070		A	NUCLEAR SCAN OF PARATHYROID	0.55	2.06	0.15	2.76	2	XXX
78070	TC	A	NUCLEAR SCAN OF PARATHYROID	0.00	1.82	0.11	1.93		XXX
78070	26	A	NUCLEAR SCAN OF PARATHYROID	0.55	0.24	0.04	0.83	2	XXX
78075		A	NUCLEAR SCAN OF ADRENALS	0.78	5.80	0.39	6.97	2	XXX
78075	TC	A	NUCLEAR SCAN OF ADRENALS	0.00	5.45	0.34	5.79		XXX
78075	26	A	NUCLEAR SCAN OF ADRENALS	0.78	0.35	0.05	1.18	2	XXX
78099		C	ENDOCRINE NUCLEAR PROCEDURE	0.00	0.00	0.00	0.00		XXX
78102		A	NUCLEAR SCAN OF BONE MARROW	0.59	2.31	0.17	3.07	2	XXX
78102	TC	A	NUCLEAR SCAN OF BONE MARROW	0.00	2.05	0.13	2.18		XXX
78102	26	A	NUCLEAR SCAN OF BONE MARROW	0.59	0.26	0.04	0.89	2	XXX
78103		A	NUCLEAR SCAN OF BONE MARROW	0.79	3.53	0.25	4.57	2	XXX
78103	TC	A	NUCLEAR SCAN OF BONE MARROW	0.00	3.18	0.20	3.38		XXX
78103	26	A	NUCLEAR SCAN OF BONE MARROW	0.79	0.35	0.05	1.19	2	XXX
78104		A	NUCLEAR SCAN OF BONE MARROW	0.84	4.46	0.31	5.61	2	XXX
78104	TC	A	NUCLEAR SCAN OF BONE MARROW	0.00	4.08	0.26	4.34		XXX
78104	26	A	NUCLEAR SCAN OF BONE MARROW	0.84	0.38	0.05	1.27	2	XXX
78110		A	NUCLEAR EXAM, PLASMA VOLUME	0.20	1.04	0.07	1.31	2	XXX
78110	TC	A	NUCLEAR EXAM, PLASMA VOLUME	0.00	0.95	0.06	1.01		XXX
78110	26	A	NUCLEAR EXAM, PLASMA VOLUME	0.20	0.09	0.01	0.30	2	XXX
78111		A	NUCLEAR EXAM, PLASMA VOLUME	0.23	2.68	0.18	3.09	2	XXX
78111	TC	A	NUCLEAR EXAM, PLASMA VOLUME	0.00	2.58	0.16	2.74		XXX
78111	26	A	NUCLEAR EXAM, PLASMA VOLUME	0.23	0.10	0.02	0.35	2	XXX
78120		A	NUCLEAR EXAM OF RBC MASS	0.24	1.85	0.13	2.22	2	XXX
78120	TC	A	NUCLEAR EXAM OF RBC MASS	0.00	1.74	0.11	1.85		XXX
78120	26	A	NUCLEAR EXAM OF RBC MASS	0.24	0.11	0.02	0.37	2	XXX
78121		A	NUCLEAR EXAM OF RBC MASS	0.33	3.07	0.20	3.60	2	XXX
78121	TC	A	NUCLEAR EXAM OF RBC MASS	0.00	2.92	0.18	3.10		XXX
78121	26	A	NUCLEAR EXAM OF RBC MASS	0.33	0.15	0.02	0.50	2	XXX
78122		A	NUCLEAR EXAM, BLOOD VOLUME	0.47	4.84	0.32	5.63	2	XXX
78122	TC	A	NUCLEAR EXAM, BLOOD VOLUME	0.00	4.63	0.29	4.92		XXX
78122	26	A	NUCLEAR EXAM, BLOOD VOLUME	0.47	0.21	0.03	0.71	2	XXX
78130		A	RED CELL SURVIVAL EXAM	0.65	3.16	0.22	4.03	2	XXX
78130	TC	A	RED CELL SURVIVAL EXAM	0.00	2.87	0.18	3.05		XXX
78130	26	A	RED CELL SURVIVAL EXAM	0.65	0.29	0.04	0.98	2	XXX
78135		A	RED CELL SURVIVAL EXAM	0.68	5.19	0.35	6.22	2	XXX
78135	TC	A	RED CELL SURVIVAL EXAM	0.00	4.89	0.31	5.20		XXX
78135	26	A	RED CELL SURVIVAL EXAM	0.68	0.30	0.04	1.02	2	XXX
78140		A	NUCLEAR EXAM, RED BLOOD CELLS	0.65	4.24	0.29	5.18	2	XXX
78140	TC	A	NUCLEAR EXAM, RED BLOOD CELLS	0.00	3.95	0.25	4.20		XXX
78140	26	A	NUCLEAR EXAM, RED BLOOD CELLS	0.65	0.29	0.04	0.98	2	XXX
78160		A	NUCLEAR EXAM OF PLASMA IRON	0.34	3.83	0.25	4.42	2	XXX
78160	TC	A	NUCLEAR EXAM OF PLASMA IRON	0.00	3.68	0.23	3.91		XXX
78160	26	A	NUCLEAR EXAM OF PLASMA IRON	0.34	0.15	0.02	0.51	2	XXX
78162		A	NUCLEAR EXAM, IRON ABSORPTION	0.47	3.42	0.23	4.12	2	XXX
78162	TC	A	NUCLEAR EXAM, IRON ABSORPTION	0.00	3.21	0.20	3.41		XXX
78162	26	A	NUCLEAR EXAM, IRON ABSORPTION	0.47	0.21	0.03	0.71	2	XXX
78170		A	NUCLEAR EXAM, RED CELL IRON	0.43	5.53	0.36	6.32	2	XXX
78170	TC	A	NUCLEAR EXAM, RED CELL IRON	0.00	5.34	0.33	5.67		XXX
78170	26	A	NUCLEAR EXAM, RED CELL IRON	0.43	0.19	0.03	0.65	2	XXX
78172		C	NUCLEAR EXAM, TOTAL BODY IRON	0.00	0.00	0.00	0.00		XXX
78172	TC	C	NUCLEAR EXAM, TOTAL BODY IRON	0.00	0.00	0.00	0.00		XXX
78172	26	A	NUCLEAR EXAM, TOTAL BODY IRON	0.57	0.26	0.04	0.87	2	XXX
78185		A	NUCLEAR SCAN OF SPLEEN	0.42	2.56	0.18	3.16	2	XXX
78185	TC	A	NUCLEAR SCAN OF SPLEEN	0.00	2.37	0.15	2.52		XXX
78185	26	A	NUCLEAR SCAN OF SPLEEN	0.42	0.19	0.03	0.64	2	XXX
78186		D	NUCLEAR SCAN OF SPLEEN	0.00	0.00	0.00	0.00		XXX
78190		A	NUCLEAR EXAM OF PLATELETS	1.14	6.25	0.43	7.82	2	XXX
78190	TC	A	NUCLEAR EXAM OF PLATELETS	0.00	5.74	0.36	6.10		XXX
78190	26	A	NUCLEAR EXAM OF PLATELETS	1.14	0.51	0.07	1.72	2	XXX
78191		A	NUCLEAR EXAM OF PLATELETS	0.65	7.66	0.50	8.81	2	XXX
78191	TC	A	NUCLEAR EXAM OF PLATELETS	0.00	7.37	0.46	7.83		XXX
78191	26	A	NUCLEAR EXAM OF PLATELETS	0.65	0.29	0.04	0.98	2	XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
78192		A	NUCLEAR EXAM, WBC SCAN	0.84	3.79	0.26	4.89	2	XXX
78192	TC	A	NUCLEAR EXAM, WBC SCAN	0.00	3.42	0.21	3.63		XXX
78192	26	A	NUCLEAR EXAM, WBC SCAN	0.84	0.37	0.05	1.26	2	XXX
78193		A	NUCLEAR EXAM, WBC SCAN	0.93	10.20	0.67	11.80	2	XXX
78193	TC	A	NUCLEAR EXAM, WBC SCAN	0.00	9.79	0.61	10.40		XXX
78193	26	A	NUCLEAR EXAM, WBC SCAN	0.93	0.41	0.06	1.40	2	XXX
78195		A	NUCLEAR SCAN OF LYMPH SYSTEM	0.74	4.41	0.31	5.46	2	XXX
78195	TC	A	NUCLEAR SCAN OF LYMPH SYSTEM	0.00	4.08	0.26	4.34		XXX
78195	26	A	NUCLEAR SCAN OF LYMPH SYSTEM	0.74	0.33	0.05	1.12	2	XXX
78199		C	NUCLEAR EXAM BLOOD/LYMPH	0.00	0.00	0.00	0.00		XXX
78201		A	NUCLEAR SCAN OF LIVER	0.46	2.57	0.18	3.21	2	XXX
78201	TC	A	NUCLEAR SCAN OF LIVER	0.00	2.37	0.15	2.52		XXX
78201	26	A	NUCLEAR SCAN OF LIVER	0.46	0.20	0.03	0.69	2	XXX
78202		A	NUCLEAR SCAN OF LIVER	0.55	3.14	0.22	3.91	2	XXX
78202	TC	A	NUCLEAR SCAN OF LIVER	0.00	2.90	0.18	3.08		XXX
78202	26	A	NUCLEAR SCAN OF LIVER	0.55	0.24	0.04	0.83	2	XXX
78205		A	NUCLEAR SCAN OF LIVER (3D)	0.75	6.26	0.42	7.43	2	XXX
78205	TC	A	NUCLEAR SCAN OF LIVER (3D)	0.00	5.92	0.37	6.29		XXX
78205	26	A	NUCLEAR SCAN OF LIVER (3D)	0.75	0.34	0.05	1.14	2	XXX
78215		A	NUCLEAR SCAN, LIVER & SPLEEN	0.52	3.18	0.21	3.91	2	XXX
78215	TC	A	NUCLEAR SCAN, LIVER & SPLEEN	0.00	2.95	0.18	3.13		XXX
78215	26	A	NUCLEAR SCAN, LIVER & SPLEEN	0.52	0.23	0.03	0.78	2	XXX
78216		A	NUCLEAR SCAN, LIVER/SPLEEN	0.61	3.77	0.26	4.64	2	XXX
78216	TC	A	NUCLEAR SCAN, LIVER/SPLEEN	0.00	3.50	0.22	3.72		XXX
78216	26	A	NUCLEAR SCAN, LIVER/SPLEEN	0.61	0.27	0.04	0.92	2	XXX
78220		A	NUCLEAR SCAN, LIVER FUNCTION	0.52	3.97	0.26	4.75	2	XXX
78220	TC	A	NUCLEAR SCAN, LIVER FUNCTION	0.00	3.74	0.23	3.97		XXX
78220	26	A	NUCLEAR SCAN, LIVER FUNCTION	0.52	0.23	0.03	0.78	2	XXX
78223		A	NUCLEAR SCAN, BILIARY TRACT	0.88	4.07	0.29	5.24	2	XXX
78223	TC	A	NUCLEAR SCAN, BILIARY TRACT	0.00	3.68	0.23	3.91		XXX
78223	26	A	NUCLEAR SCAN, BILIARY TRACT	0.88	0.39	0.06	1.33	2	XXX
78225		D	NUCLEAR SCAN, LIVER/LUNG	0.00	0.00	0.00	0.00		XXX
78230		A	NUCLEAR SCAN, SALIVARY GLAND	0.48	2.40	0.17	3.05	2	XXX
78230	TC	A	NUCLEAR SCAN, SALIVARY GLAND	0.00	2.18	0.14	2.32		XXX
78230	26	A	NUCLEAR SCAN, SALIVARY GLAND	0.48	0.22	0.03	0.73	2	XXX
78231		A	NUCLEAR SCANS, SALIVARY GLAND	0.56	3.43	0.24	4.23	2	XXX
78231	TC	A	NUCLEAR SCANS, SALIVARY GLAND	0.00	3.18	0.20	3.38		XXX
78231	26	A	NUCLEAR SCANS, SALIVARY GLAND	0.56	0.25	0.04	0.85	2	XXX
78232		A	NUCLEAR EXAM, SALIVARY GLAND	0.50	3.78	0.25	4.53	2	XXX
78232	TC	A	NUCLEAR EXAM, SALIVARY GLAND	0.00	3.55	0.22	3.77		XXX
78232	26	A	NUCLEAR EXAM, SALIVARY GLAND	0.50	0.23	0.03	0.76	2	XXX
78258		A	NUCLEAR IMAGING OF ESOPHAGUS	0.78	3.25	0.23	4.26	2	XXX
78258	TC	A	NUCLEAR IMAGING OF ESOPHAGUS	0.00	2.90	0.18	3.08		XXX
78258	26	A	NUCLEAR IMAGING OF ESOPHAGUS	0.78	0.35	0.05	1.18	2	XXX
78261		A	NUCLEAR SCAN, GASTRIC MUCOSA	0.73	4.44	0.31	5.48	2	XXX
78261	TC	A	NUCLEAR SCAN, GASTRIC MUCOSA	0.00	4.11	0.26	4.37		XXX
78261	26	A	NUCLEAR SCAN, GASTRIC MUCOSA	0.73	0.33	0.05	1.11	2	XXX
78262		A	GULLET REFLUX NUCLEAR EXAM	0.72	4.58	0.32	5.62	2	XXX
78262	TC	A	GULLET REFLUX NUCLEAR EXAM	0.00	4.26	0.27	4.53		XXX
78262	26	A	GULLET REFLUX NUCLEAR EXAM	0.72	0.32	0.05	1.09	2	XXX
78264		A	NUCLEAR EXAM, STOMACH	0.82	4.50	0.31	5.63	2	XXX
78264	TC	A	NUCLEAR EXAM, STOMACH	0.00	4.13	0.26	4.39		XXX
78264	26	A	NUCLEAR EXAM, STOMACH	0.82	0.37	0.05	1.24	2	XXX
78270		A	VIT B-12 ABSORPTION EXAMS	0.21	1.65	0.11	1.97	2	XXX
78270	TC	A	VIT B-12 ABSORPTION EXAMS	0.00	1.55	0.10	1.65		XXX
78270	26	A	VIT B-12 ABSORPTION EXAMS	0.21	0.10	0.01	0.32	2	XXX
78271		A	VIT B-12 ABSORPTION EXAMS	0.21	1.76	0.11	2.08	2	XXX
78271	TC	A	VIT B-12 ABSORPTION EXAMS	0.00	1.66	0.10	1.76		XXX
78271	26	A	VIT B-12 ABSORPTION EXAMS	0.21	0.10	0.01	0.32	2	XXX
78272		A	VIT B-12 ABSORPTION EXAMS	0.28	2.45	0.17	2.90	2	XXX
78272	TC	A	VIT B-12 ABSORPTION EXAMS	0.00	2.32	0.15	2.47		XXX
78272	26	A	VIT B-12 ABSORPTION EXAMS	0.28	0.13	0.02	0.43	2	XXX
78276		A	NUCLEAR EXAM, GI BLOOD LOSS	0.75	3.55	0.25	4.55	2	XXX
78276	TC	A	NUCLEAR EXAM, GI BLOOD LOSS	0.00	3.21	0.20	3.41		XXX
78276	26	A	NUCLEAR EXAM, GI BLOOD LOSS	0.75	0.34	0.05	1.14	2	XXX
78278		A	NUCLEAR SCAN, GI BLOOD LOSS	1.04	5.36	0.38	6.78	2	XXX
78278	TC	A	NUCLEAR SCAN, GI BLOOD LOSS	0.00	4.89	0.31	5.20		XXX
78278	26	A	NUCLEAR SCAN, GI BLOOD LOSS	1.04	0.47	0.07	1.58	2	XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPs*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
78280		A	G.I. BLOOD LOSS EXAM	0.40	3.44	0.23	4.07	2	XXX
78280	TC	A	G.I. BLOOD LOSS EXAM	0.00	3.26	0.20	3.46		XXX
78280	26	A	G.I. BLOOD LOSS EXAM	0.40	0.18	0.03	0.61	2	XXX
78282		C	G.I. PROTEIN LOSS EXAM	0.00	0.00	0.00	0.00		XXX
78282	TC	C	G.I. PROTEIN LOSS EXAM	0.00	0.00	0.00	0.00		XXX
78282	26	A	G.I. PROTEIN LOSS EXAM	0.40	0.18	0.03	0.61	2	XXX
78290		A	NUCLEAR SCAN OF BOWEL	0.72	3.37	0.24	4.33	2	XXX
78290	TC	A	NUCLEAR SCAN OF BOWEL	0.00	3.05	0.19	3.24		XXX
78290	26	A	NUCLEAR SCAN OF BOWEL	0.72	0.32	0.05	1.09	2	XXX
78291		A	TEST VENOUS DRAIN, ABDOMEN	0.93	3.49	0.25	4.67	2	XXX
78291	TC	A	TEST VENOUS DRAIN, ABDOMEN	0.00	3.08	0.19	3.27		XXX
78291	26	A	TEST VENOUS DRAIN, ABDOMEN	0.93	0.41	0.06	1.40	2	XXX
78299		C	G.I. NUCLEAR PROCEDURE	0.00	0.00	0.00	0.00		XXX
78300		A	NUCLEAR SCAN OF BONE	0.66	2.80	0.20	3.66	2	XXX
78300	TC	A	NUCLEAR SCAN OF BONE	0.00	2.50	0.16	2.66		XXX
78300	26	A	NUCLEAR SCAN OF BONE	0.66	0.30	0.04	1.00	2	XXX
78305		A	NUCLEAR SCAN OF BONES	0.87	4.07	0.29	5.23	2	XXX
78305	TC	A	NUCLEAR SCAN OF BONES	0.00	3.68	0.23	3.91		XXX
78305	26	A	NUCLEAR SCAN OF BONES	0.87	0.39	0.06	1.32	2	XXX
78306		A	NUCLEAR SCAN OF SKELETON	0.91	4.70	0.33	5.94	2	XXX
78306	TC	A	NUCLEAR SCAN OF SKELETON	0.00	4.29	0.27	4.56		XXX
78306	26	A	NUCLEAR SCAN OF SKELETON	0.91	0.41	0.06	1.38	2	XXX
78310		A	BONE BLOOD FLOW SCAN	0.58	1.44	0.11	2.13	2	XXX
78310	TC	A	BONE BLOOD FLOW SCAN	0.00	1.18	0.07	1.25		XXX
78310	26	A	BONE BLOOD FLOW SCAN	0.58	0.26	0.04	0.88	2	XXX
78315		A	NUCLEAR SCAN OF BONE	1.07	5.27	0.37	6.71	2	XXX
78315	TC	A	NUCLEAR SCAN OF BONE	0.00	4.79	0.30	5.09		XXX
78315	26	A	NUCLEAR SCAN OF BONE	1.07	0.48	0.07	1.62	2	XXX
78320		A	NUCLEAR SCAN OF BONE (3D)	1.09	6.41	0.44	7.94	2	XXX
78320	TC	A	NUCLEAR SCAN OF BONE (3D)	0.00	5.92	0.37	6.29		XXX
78320	26	A	NUCLEAR SCAN OF BONE (3D)	1.09	0.49	0.07	1.65	2	XXX
78350		A	BONE MINERAL CONTENT STUDY	0.23	0.86	0.07	1.16	2	XXX
78350	TC	A	BONE MINERAL CONTENT STUDY	0.00	0.76	0.05	0.81		XXX
78350	26	A	BONE MINERAL CONTENT STUDY	0.23	0.10	0.02	0.35	2	XXX
78351		N	BONE MINERAL CONTENT STUDY	0.00	0.00	0.00	0.00		XXX
78399		C	MUSCULOSKELETAL NUCLEAR EXAM	0.00	0.00	0.00	0.00		XXX
78414		C	NUCLEAR EXAM OF HEART FLOW	0.00	0.00	0.00	0.00		XXX
78414	TC	C	NUCLEAR EXAM OF HEART FLOW	0.00	0.00	0.00	0.00		XXX
78414	26	A	NUCLEAR EXAM OF HEART FLOW	0.47	0.21	0.03	0.71	2	XXX
78415		D	NUCLEAR SCAN OF HEART BLOOD	0.00	0.00	0.00	0.00		XXX
78425		D	NUCLEAR SCAN, HEART MUSCLE	0.00	0.00	0.00	0.00		XXX
78428		A	NUCLEAR EXAM, HEART SHUNT	0.82	2.63	0.19	3.64	2	XXX
78428	TC	A	NUCLEAR EXAM, HEART SHUNT	0.00	2.26	0.14	2.40		XXX
78428	26	A	NUCLEAR EXAM, HEART SHUNT	0.82	0.37	0.05	1.24	2	XXX
78435		D	NUCLEAR SCAN OF HEART FLOW	0.00	0.00	0.00	0.00		XXX
78445		A	NUCLEAR SCAN OF BLOOD FLOW	0.52	2.12	0.15	2.79	2	XXX
78445	TC	A	NUCLEAR SCAN OF BLOOD FLOW	0.00	1.89	0.12	2.01		XXX
78445	26	A	NUCLEAR SCAN OF BLOOD FLOW	0.52	0.23	0.03	0.78	2	XXX
78455		A	NUCLEAR SCAN OF VEIN CLOT	0.77	4.34	0.30	5.41	2	XXX
78455	TC	A	NUCLEAR SCAN OF VEIN CLOT	0.00	4.00	0.25	4.25		XXX
78455	26	A	NUCLEAR SCAN OF VEIN CLOT	0.77	0.34	0.05	1.16	2	XXX
78457		A	NUCLEAR SCAN VEIN THROMBOSIS	0.81	3.02	0.22	4.05	2	XXX
78457	TC	A	NUCLEAR SCAN VEIN THROMBOSIS	0.00	2.66	0.17	2.83		XXX
78457	26	A	NUCLEAR SCAN VEIN THROMBOSIS	0.81	0.36	0.05	1.22	2	XXX
78458		A	NUCLEAR SCAN VEIN THROMBOSIS	0.95	4.45	0.31	5.71	2	XXX
78458	TC	A	NUCLEAR SCAN VEIN THROMBOSIS	0.00	4.03	0.25	4.28		XXX
78458	26	A	NUCLEAR SCAN VEIN THROMBOSIS	0.95	0.42	0.06	1.43	2	XXX
78460		A	NUCLEAR SCAN, HEART MUSCLE	0.91	2.78	0.21	3.90	2	XXX
78460	TC	A	NUCLEAR SCAN, HEART MUSCLE	0.00	2.37	0.15	2.52		XXX
78460	26	A	NUCLEAR SCAN, HEART MUSCLE	0.91	0.41	0.06	1.38	2	XXX
78461		A	NUCLEAR SCAN, HEART MUSCLE	1.30	5.32	0.38	7.00	2	XXX
78461	TC	A	NUCLEAR SCAN, HEART MUSCLE	0.00	4.74	0.30	5.04		XXX
78461	26	A	NUCLEAR SCAN, HEART MUSCLE	1.30	0.58	0.08	1.96	2	XXX
78464		A	NUCLEAR SCAN, HEART MUSCLE	1.14	7.62	0.52	9.28	2	XXX
78464	TC	A	NUCLEAR SCAN, HEART MUSCLE	0.00	7.11	0.45	7.56		XXX
78464	26	A	NUCLEAR SCAN, HEART MUSCLE	1.14	0.51	0.07	1.72	2	XXX
78465		A	NUCLEAR SCAN, HEART MUSCLE	1.54	12.53	0.84	14.91	2	XXX
78465	TC	A	NUCLEAR SCAN, HEART MUSCLE	0.00	11.84	0.74	12.58		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
78465	26	A	NUCLEAR SCAN, HEART MUSCLE	1.54	0.69	0.10	2.33	2	XXX
78466		A	NUCLEAR SCAN, HEART MUSCLE	0.73	2.96	0.22	3.91	2	XXX
78466	TC	A	NUCLEAR SCAN, HEART MUSCLE	0.00	2.63	0.17	2.80		XXX
78466	26	A	NUCLEAR SCAN, HEART MUSCLE	0.73	0.33	0.05	1.11	2	XXX
78467		D	NUCLEAR SCAN, HEART MUSCLE	0.00	0.00	0.00	0.00		XXX
78468		A	NUCLEAR SCAN, HEART MUSCLE	0.84	4.05	0.28	5.17	2	XXX
78468	TC	A	NUCLEAR SCAN, HEART MUSCLE	0.00	3.68	0.23	3.91		XXX
78468	26	A	NUCLEAR SCAN, HEART MUSCLE	0.84	0.37	0.05	1.26	2	XXX
78469		A	NUCLEAR SCAN, HEART MUSCLE	0.97	5.69	0.39	7.05	2	XXX
78469	TC	A	NUCLEAR SCAN, HEART MUSCLE	0.00	5.26	0.33	5.59		XXX
78469	26	A	NUCLEAR SCAN, HEART MUSCLE	0.97	0.43	0.06	1.46	2	XXX
78470		D	NUCLEAR STUDY, HEART OUTPUT	0.00	0.00	0.00	0.00		XXX
78471		D	NUCLEAR SCAN, HEART MUSCLE	0.00	0.00	0.00	0.00		XXX
78472		A	NUCLEAR SCAN, HEART MUSCLE	1.03	5.99	0.42	7.44	2	XXX
78472	TC	A	NUCLEAR SCAN, HEART MUSCLE	0.00	5.53	0.35	5.88		XXX
78472	26	A	NUCLEAR SCAN, HEART MUSCLE	1.03	0.46	0.07	1.56	2	XXX
78473		A	NUCLEAR SCAN, CARDIAC MUGA	1.55	8.98	0.62	11.15	2	XXX
78473	TC	A	NUCLEAR SCAN, CARDIAC MUGA	0.00	8.29	0.52	8.81		XXX
78473	26	A	NUCLEAR SCAN, CARDIAC MUGA	1.55	0.69	0.10	2.34	2	XXX
78474		D	NUCLEAR SCAN, HEART MUSCLE	0.00	0.00	0.00	0.00		XXX
78475		D	NUCLEAR SCAN, HEART MUSCLE	0.00	0.00	0.00	0.00		XXX
78476		D	NUCLEAR SCAN, HEART MUSCLE	0.00	0.00	0.00	0.00		XXX
78477		D	NUCLEAR SCAN, HEART MUSCLE	0.00	0.00	0.00	0.00		XXX
78478		A	NUCLEAR SCAN, HEART MUSCLE	0.66	1.85	0.14	2.65	2	XXX
78478	TC	A	NUCLEAR SCAN, HEART MUSCLE	0.00	1.56	0.10	1.66		XXX
78478	26	A	NUCLEAR SCAN, HEART MUSCLE	0.66	0.29	0.04	0.99	2	XXX
78479		D	NUCLEAR SCAN, HEART MUSCLE	0.00	0.00	0.00	0.00		XXX
78480		A	NUCLEAR SCAN, HEART MUSCLE	0.66	1.85	0.14	2.65	2	XXX
78480	TC	A	NUCLEAR SCAN, HEART MUSCLE	0.00	1.56	0.10	1.66		XXX
78480	26	A	NUCLEAR SCAN, HEART MUSCLE	0.66	0.29	0.04	0.99	2	XXX
78481		A	NUCLEAR SCAN, HEART MUSCLE	1.03	5.72	0.40	7.15	2	XXX
78481	TC	A	NUCLEAR SCAN, HEART MUSCLE	0.00	5.26	0.33	5.59		XXX
78481	26	A	NUCLEAR SCAN, HEART MUSCLE	1.03	0.46	0.07	1.56	2	XXX
78483		A	NUCLEAR SCAN, HEART MUSCLE	1.55	8.59	0.60	10.74	2	XXX
78483	TC	A	NUCLEAR SCAN, HEART MUSCLE	0.00	7.90	0.50	8.40		XXX
78483	26	A	NUCLEAR SCAN, HEART MUSCLE	1.55	0.69	0.10	2.34	2	XXX
78484		D	NUCLEAR SCAN, HEART MUSCLE	0.00	0.00	0.00	0.00		XXX
78485		D	NUCLEAR SCAN, HEART MUSCLE	0.00	0.00	0.00	0.00		XXX
78486		D	NUCLEAR SCAN, HEART MUSCLE	0.00	0.00	0.00	0.00		XXX
78487		D	NUCLEAR SCAN, HEART MUSCLE	0.00	0.00	0.00	0.00		XXX
78489		D	NUCLEAR SCAN, HEART MUSCLE	0.00	0.00	0.00	0.00		XXX
78499		C	CARDIOVASCULAR NUCLEAR EXAM	0.00	0.00	0.00	0.00		XXX
78580		A	NUCLEAR SCAN OF LUNG	0.78	3.80	0.27	4.85	2	XXX
78580	TC	A	NUCLEAR SCAN OF LUNG	0.00	3.45	0.22	3.67		XXX
78580	26	A	NUCLEAR SCAN OF LUNG	0.78	0.35	0.05	1.18	2	XXX
78581		A	NUCLEAR SCAN OF LUNG	0.73	2.73	0.20	3.66	2	XXX
78581	TC	A	NUCLEAR SCAN OF LUNG	0.00	2.40	0.15	2.55		XXX
78581	26	A	NUCLEAR SCAN OF LUNG	0.73	0.33	0.05	1.11	2	XXX
78582		A	NUCLEAR SCAN OF LUNG	0.96	4.22	0.30	5.48	2	XXX
78582	TC	A	NUCLEAR SCAN OF LUNG	0.00	3.79	0.24	4.03		XXX
78582	26	A	NUCLEAR SCAN OF LUNG	0.96	0.43	0.06	1.45	2	XXX
78584		A	NUCLEAR SCAN OF LUNG	1.04	3.68	0.27	4.99	2	XXX
78584	TC	A	NUCLEAR SCAN OF LUNG	0.00	3.21	0.20	3.41		XXX
78584	26	A	NUCLEAR SCAN OF LUNG	1.04	0.47	0.07	1.58	2	XXX
78585		A	NUCLEAR SCAN OF LUNG	1.14	6.17	0.42	7.73	2	XXX
78585	TC	A	NUCLEAR SCAN OF LUNG	0.00	5.66	0.35	6.01		XXX
78585	26	A	NUCLEAR SCAN OF LUNG	1.14	0.51	0.07	1.72	2	XXX
78586		A	NUCLEAR SCAN OF LUNG	0.42	2.79	0.19	3.40	2	XXX
78586	TC	A	NUCLEAR SCAN OF LUNG	0.00	2.60	0.16	2.76		XXX
78586	26	A	NUCLEAR SCAN OF LUNG	0.42	0.19	0.03	0.64	2	XXX
78587		A	NUCLEAR SCAN OF LUNG	0.52	3.05	0.21	3.78	2	XXX
78587	TC	A	NUCLEAR SCAN OF LUNG	0.00	2.82	0.18	3.00		XXX
78587	26	A	NUCLEAR SCAN OF LUNG	0.52	0.23	0.03	0.78	2	XXX
78591		A	NUCLEAR SCAN OF LUNG	0.42	3.06	0.21	3.69	2	XXX
78591	TC	A	NUCLEAR SCAN OF LUNG	0.00	2.87	0.18	3.05		XXX
78591	26	A	NUCLEAR SCAN OF LUNG	0.42	0.19	0.03	0.64	2	XXX
78593		A	NUCLEAR SCAN OF LUNG	0.52	3.70	0.25	4.47	2	XXX
78593	TC	A	NUCLEAR SCAN OF LUNG	0.00	3.47	0.22	3.69		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
78593	26	A	NUCLEAR SCAN OF LUNG	0.52	0.23	0.03	0.78	2	XXX
78594		A	NUCLEAR SCAN OF LUNG	0.57	5.26	0.35	6.18	2	XXX
78594	TC	A	NUCLEAR SCAN OF LUNG	0.00	5.00	0.31	5.31		XXX
78594	26	A	NUCLEAR SCAN OF LUNG	0.57	0.26	0.04	0.87	2	XXX
78596		A	NUCLEAR STUDY OF LUNG	1.34	7.71	0.54	9.59	2	XXX
78596	TC	A	NUCLEAR STUDY OF LUNG	0.00	7.11	0.45	7.56		XXX
78596	26	A	NUCLEAR STUDY OF LUNG	1.34	0.60	0.09	2.03	2	XXX
78599		C	RESPIRATORY NUCLEAR EXAM	0.00	0.00	0.00	0.00		XXX
78600		A	NUCLEAR SCAN OF BRAIN	0.46	3.11	0.21	3.78	2	XXX
78600	TC	A	NUCLEAR SCAN OF BRAIN	0.00	2.90	0.18	3.08		XXX
78600	26	A	NUCLEAR SCAN OF BRAIN	0.46	0.21	0.03	0.70	2	XXX
78601		A	NUCLEAR SCAN OF BRAIN	0.55	3.67	0.25	4.47	2	XXX
78601	TC	A	NUCLEAR SCAN OF BRAIN	0.00	3.42	0.21	3.63		XXX
78601	26	A	NUCLEAR SCAN OF BRAIN	0.55	0.25	0.04	0.84	2	XXX
78605		A	NUCLEAR SCAN OF BRAIN	0.57	3.68	0.25	4.50	2	XXX
78605	TC	A	NUCLEAR SCAN OF BRAIN	0.00	3.42	0.21	3.63		XXX
78605	26	A	NUCLEAR SCAN OF BRAIN	0.57	0.26	0.04	0.87	2	XXX
78606		A	NUCLEAR SCAN OF BRAIN	0.68	4.19	0.28	5.15	2	XXX
78606	TC	A	NUCLEAR SCAN OF BRAIN	0.00	3.89	0.24	4.13		XXX
78606	26	A	NUCLEAR SCAN OF BRAIN	0.68	0.30	0.04	1.02	2	XXX
78607		A	NUCLEAR SCAN OF BRAIN (3D)	1.30	7.16	0.49	8.95	2	XXX
78607	TC	A	NUCLEAR SCAN OF BRAIN (3D)	0.00	6.58	0.41	6.99		XXX
78607	26	A	NUCLEAR SCAN OF BRAIN (3D)	1.30	0.58	0.08	1.96	2	XXX
78610		A	NUCLEAR SCAN OF BRAIN	0.31	1.72	0.12	2.15	2	XXX
78610	TC	A	NUCLEAR SCAN OF BRAIN	0.00	1.58	0.10	1.68		XXX
78610	26	A	NUCLEAR SCAN OF BRAIN	0.31	0.14	0.02	0.47	2	XXX
78615		A	CEREBRAL BLOOD FLOW SCAN	0.44	4.07	0.27	4.78	2	XXX
78615	TC	A	CEREBRAL BLOOD FLOW SCAN	0.00	3.87	0.24	4.11		XXX
78615	26	A	CEREBRAL BLOOD FLOW SCAN	0.44	0.20	0.03	0.67	2	XXX
78630		A	CEREBROSPINAL FLUID SCAN	0.72	5.37	0.37	6.46	2	XXX
78630	TC	A	CEREBROSPINAL FLUID SCAN	0.00	5.05	0.32	5.37		XXX
78630	26	A	CEREBROSPINAL FLUID SCAN	0.72	0.32	0.05	1.09	2	XXX
78635		A	CEREBROSPINAL FLUID SCAN	0.65	2.84	0.20	3.69	2	XXX
78635	TC	A	CEREBROSPINAL FLUID SCAN	0.00	2.55	0.16	2.71		XXX
78635	26	A	CEREBROSPINAL FLUID SCAN	0.65	0.29	0.04	0.98	2	XXX
78645		A	CEREBROSPINAL FLUID SCAN	0.61	3.72	0.26	4.59	2	XXX
78645	TC	A	CEREBROSPINAL FLUID SCAN	0.00	3.45	0.22	3.67		XXX
78645	26	A	CEREBROSPINAL FLUID SCAN	0.61	0.27	0.04	0.92	2	XXX
78650		A	CEREBROSPINAL FLUID SCAN	0.65	4.95	0.33	5.93	2	XXX
78650	TC	A	CEREBROSPINAL FLUID SCAN	0.00	4.66	0.29	4.95		XXX
78650	26	A	CEREBROSPINAL FLUID SCAN	0.65	0.29	0.04	0.98	2	XXX
78652		A	CEREBROSPINAL FLUID SCAN(3D)	0.95	6.35	0.43	7.73	2	XXX
78652	TC	A	CEREBROSPINAL FLUID SCAN(3D)	0.00	5.92	0.37	6.29		XXX
78652	26	A	CEREBROSPINAL FLUID SCAN(3D)	0.95	0.43	0.06	1.44	2	XXX
78655		A	NUCLEAR EXAM OF EYE LESION	0.60	5.27	0.35	6.22	2	XXX
78655	TC	A	NUCLEAR EXAM OF EYE LESION	0.00	5.00	0.31	5.31		XXX
78655	26	A	NUCLEAR EXAM OF EYE LESION	0.60	0.27	0.04	0.91	2	XXX
78660		A	NUCLEAR EXAM OF TEAR FLOW	0.57	2.39	0.17	3.13	2	XXX
78660	TC	A	NUCLEAR EXAM OF TEAR FLOW	0.00	2.13	0.13	2.26		XXX
78660	26	A	NUCLEAR EXAM OF TEAR FLOW	0.57	0.26	0.04	0.87	2	XXX
78699		C	NERVOUS SYSTEM NUCLEAR EXAM	0.00	0.00	0.00	0.00		XXX
78700		A	NUCLEAR SCAN OF KIDNEY	0.47	3.26	0.22	3.95	2	XXX
78700	TC	A	NUCLEAR SCAN OF KIDNEY	0.00	3.05	0.19	3.24		XXX
78700	26	A	NUCLEAR SCAN OF KIDNEY	0.47	0.21	0.03	0.71	2	XXX
78701		A	NUCLEAR SCAN OF KIDNEY	0.52	3.81	0.25	4.58	2	XXX
78701	TC	A	NUCLEAR SCAN OF KIDNEY	0.00	3.58	0.22	3.80		XXX
78701	26	A	NUCLEAR SCAN OF KIDNEY	0.52	0.23	0.03	0.78	2	XXX
78704		A	NUCLEAR SCAN OF KIDNEY	0.78	4.32	0.30	5.40	2	XXX
78704	TC	A	NUCLEAR SCAN OF KIDNEY	0.00	3.97	0.25	4.22		XXX
78704	26	A	NUCLEAR SCAN OF KIDNEY	0.78	0.35	0.05	1.18	2	XXX
78707		A	NUCLEAR SCAN OF KIDNEY	0.99	4.94	0.34	6.27	2	XXX
78707	TC	A	NUCLEAR SCAN OF KIDNEY	0.00	4.50	0.28	4.78		XXX
78707	26	A	NUCLEAR SCAN OF KIDNEY	0.99	0.44	0.06	1.49	2	XXX
78710		A	NUCLEAR SCAN OF KIDNEY (3D)	0.70	6.23	0.42	7.35	2	XXX
78710	TC	A	NUCLEAR SCAN OF KIDNEY (3D)	0.00	5.92	0.37	6.29		XXX
78710	26	A	NUCLEAR SCAN OF KIDNEY (3D)	0.70	0.31	0.05	1.06	2	XXX
78715		A	NUCLEAR EXAM OF KIDNEY	0.31	1.72	0.12	2.15	2	XXX
78715	TC	A	NUCLEAR EXAM OF KIDNEY	0.00	1.58	0.10	1.68		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
78715	26	A	NUCLEAR EXAM OF KIDNEY	0.31	0.14	0.02	0.47	2	XXX
78725		A	NUCLEAR EXAM OF KIDNEY	0.39	1.96	0.14	2.49	2	XXX
78725	TC	A	NUCLEAR EXAM OF KIDNEY	0.00	1.79	0.11	1.90		XXX
78725	26	A	NUCLEAR EXAM OF KIDNEY	0.39	0.17	0.03	0.59	2	XXX
78726		A	NUCLEAR EXAM OF KIDNEY	0.92	3.38	0.25	4.55	2	XXX
78726	TC	A	NUCLEAR EXAM OF KIDNEY	0.00	2.97	0.19	3.16		XXX
78726	26	A	NUCLEAR EXAM OF KIDNEY	0.92	0.41	0.06	1.39	2	XXX
78727		A	NUCLEAR EXAM RENAL SURGERY	1.04	4.47	0.32	5.83	2	XXX
78727	TC	A	NUCLEAR EXAM RENAL SURGERY	0.00	4.00	0.25	4.25		XXX
78727	26	A	NUCLEAR EXAM RENAL SURGERY	1.04	0.47	0.07	1.58	2	XXX
78730		A	NUCLEAR EXAM OF BLADDER	0.37	1.63	0.11	2.11	2	XXX
78730	TC	A	NUCLEAR EXAM OF BLADDER	0.00	1.47	0.09	1.56		XXX
78730	26	A	NUCLEAR EXAM OF BLADDER	0.37	0.16	0.02	0.55	2	XXX
78740		A	NUCLEAR EXAM OF URETER	0.61	2.40	0.17	3.18	2	XXX
78740	TC	A	NUCLEAR EXAM OF URETER	0.00	2.13	0.13	2.26		XXX
78740	26	A	NUCLEAR EXAM OF URETER	0.61	0.27	0.04	0.92	2	XXX
78760		A	NUCLEAR SCAN OF TESTES	0.70	2.99	0.21	3.90	2	XXX
78760	TC	A	NUCLEAR SCAN OF TESTES	0.00	2.68	0.17	2.85		XXX
78760	26	A	NUCLEAR SCAN OF TESTES	0.70	0.31	0.04	1.05	2	XXX
78761		A	SCAN OF TESTES/BLOOD FLOW	0.75	3.55	0.25	4.55	2	XXX
78761	TC	A	SCAN OF TESTES/BLOOD FLOW	0.00	3.21	0.20	3.41		XXX
78761	26	A	SCAN OF TESTES/BLOOD FLOW	0.75	0.34	0.05	1.14	2	XXX
78799		C	GENITOURINARY NUCLEAR EXAM	0.00	0.00	0.00	0.00		XXX
78800		A	NUCLEAR EXAM OF LESION	0.69	3.73	0.25	4.67	2	XXX
78800	TC	A	NUCLEAR EXAM OF LESION	0.00	3.42	0.21	3.63		XXX
78800	26	A	NUCLEAR EXAM OF LESION	0.69	0.31	0.04	1.04	2	XXX
78801		A	NUCLEAR EXAM OF LESIONS	0.83	4.61	0.32	5.76	2	XXX
78801	TC	A	NUCLEAR EXAM OF LESIONS	0.00	4.24	0.27	4.51		XXX
78801	26	A	NUCLEAR EXAM OF LESIONS	0.83	0.37	0.05	1.25	2	XXX
78802		A	NUCLEAR EXAM OF LESIONS	0.91	5.96	0.41	7.28	2	XXX
78802	TC	A	NUCLEAR EXAM OF LESIONS	0.00	5.55	0.35	5.90		XXX
78802	26	A	NUCLEAR EXAM OF LESIONS	0.91	0.41	0.06	1.38	2	XXX
78803		A	NUCLEAR SCAN OF TUMOR (3D)	1.14	7.09	0.48	8.71	2	XXX
78803	TC	A	NUCLEAR SCAN OF TUMOR (3D)	0.00	6.58	0.41	6.99		XXX
78803	26	A	NUCLEAR SCAN OF TUMOR (3D)	1.14	0.51	0.07	1.72	2	XXX
78805		A	NUCLEAR EXAM OF ABSCESS	0.72	3.74	0.26	4.72	2	XXX
78805	TC	A	NUCLEAR EXAM OF ABSCESS	0.00	3.42	0.21	3.63		XXX
78805	26	A	NUCLEAR EXAM OF ABSCESS	0.72	0.32	0.05	1.09	2	XXX
78806		A	NUCLEAR EXAM OF ABSCESS	0.90	5.95	0.41	7.26	2	XXX
78806	TC	A	NUCLEAR EXAM OF ABSCESS	0.00	5.55	0.35	5.90		XXX
78806	26	A	NUCLEAR EXAM OF ABSCESS	0.90	0.40	0.06	1.36	2	XXX
78890		A	AUTOMATED DATA, NUCLEAR MED	0.05	1.33	0.08	1.46	2	XXX
78890	TC	A	AUTOMATED DATA, NUCLEAR MED	0.00	1.31	0.08	1.39		XXX
78890	26	A	AUTOMATED DATA, NUCLEAR MED	0.05	0.02	0.00	0.07	2	XXX
78891		A	AUTOMATED DATA, NUCLEAR MED	0.10	2.68	0.18	2.96	2	XXX
78891	TC	A	AUTOMATED DATA, NUCLEAR MED	0.00	2.63	0.17	2.80		XXX
78891	26	A	AUTOMATED DATA, NUCLEAR MED	0.10	0.05	0.01	0.16	2	XXX
78990		C	PROVIDE RADIOISOTOPE(S)	0.00	0.00	0.00	0.00		XXX
78999		C	NUCLEAR DIAGNOSTIC EXAM	0.00	0.00	0.00	0.00		XXX
79000		A	NUCLEAR THERAPY, THYROID	1.89	3.48	0.29	5.66	2	XXX
79000	TC	A	NUCLEAR THERAPY, THYROID	0.00	2.63	0.17	2.80		XXX
79000	26	A	NUCLEAR THERAPY, THYROID	1.89	0.85	0.12	2.86	2	XXX
79001		A	NUCLEAR THERAPY, THYROID	1.10	1.80	0.15	3.05	2	XXX
79001	TC	A	NUCLEAR THERAPY, THYROID	0.00	1.31	0.08	1.39		XXX
79001	26	A	NUCLEAR THERAPY, THYROID	1.10	0.49	0.07	1.66	2	XXX
79020		A	NUCLEAR THERAPY, THYROID	1.90	3.48	0.29	5.67	2	XXX
79020	TC	A	NUCLEAR THERAPY, THYROID	0.00	2.63	0.17	2.80		XXX
79020	26	A	NUCLEAR THERAPY, THYROID	1.90	0.85	0.12	2.87	2	XXX
79030		A	NUCLEAR THERAPY, THYROID	2.21	3.62	0.31	6.14	2	XXX
79030	TC	A	NUCLEAR THERAPY, THYROID	0.00	2.63	0.17	2.80		XXX
79030	26	A	NUCLEAR THERAPY, THYROID	2.21	0.99	0.14	3.34	2	XXX
79035		A	NUCLEAR THERAPY, THYROID	2.65	3.81	0.34	6.80	2	XXX
79035	TC	A	NUCLEAR THERAPY, THYROID	0.00	2.63	0.17	2.80		XXX
79035	26	A	NUCLEAR THERAPY, THYROID	2.65	1.18	0.17	4.00	2	XXX
79100		A	NUCLEAR THERAPY, BLOOD	1.39	3.25	0.26	4.90	2	XXX
79100	TC	A	NUCLEAR THERAPY, BLOOD	0.00	2.63	0.17	2.80		XXX
79100	26	A	NUCLEAR THERAPY, BLOOD	1.39	0.62	0.09	2.10	2	XXX
79200		A	RADIONUCLIDE THERAPY	2.10	3.57	0.31	5.98	2	XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
79200	TC	A	RADIONUCLIDE THERAPY	0.00	2.63	0.17	2.80		XXX
79200	26	A	RADIONUCLIDE THERAPY	2.10	0.94	0.14	3.18	2	XXX
79300		C	RADIONUCLIDE THERAPY	0.00	0.00	0.00	0.00		XXX
79300	TC	C	RADIONUCLIDE THERAPY	0.00	0.00	0.00	0.00		XXX
79300	26	A	RADIONUCLIDE THERAPY	1.69	0.75	0.11	2.55	2	XXX
79400		A	RADIONUCLIDE THERAPY	2.07	3.55	0.30	5.92	2	XXX
79400	TC	A	RADIONUCLIDE THERAPY	0.00	2.63	0.17	2.80		XXX
79400	26	A	RADIONUCLIDE THERAPY	2.07	0.92	0.13	3.12	2	XXX
79420		C	RADIONUCLIDE THERAPY	0.00	0.00	0.00	0.00		XXX
79420	TC	C	RADIONUCLIDE THERAPY	0.00	0.00	0.00	0.00		XXX
79420	26	A	RADIONUCLIDE THERAPY	1.59	0.71	0.10	2.40	2	XXX
79440		A	RADIONUCLIDE THERAPY	2.10	3.57	0.31	5.98	2	XXX
79440	TC	A	RADIONUCLIDE THERAPY	0.00	2.63	0.17	2.80		XXX
79440	26	A	RADIONUCLIDE THERAPY	2.10	0.94	0.14	3.18	2	XXX
79900		C	PROVIDE RADIOISOTOPE(S)	0.00	0.00	0.00	0.00		XXX
79999		C	NUCLEAR MEDICINE THERAPY	0.00	0.00	0.00	0.00		XXX
80002		X	1-2 CLINICAL CHEM TESTS	0.00	0.00	0.00	0.00		XXX
80003		X	3 CLINICAL CHEMISTRY TESTS	0.00	0.00	0.00	0.00		XXX
80004		X	4 CLINICAL CHEMISTRY TESTS	0.00	0.00	0.00	0.00		XXX
80005		X	5 CLINICAL CHEMISTRY TESTS	0.00	0.00	0.00	0.00		XXX
80006		X	6 CLINICAL CHEMISTRY TESTS	0.00	0.00	0.00	0.00		XXX
80007		X	7 CLINICAL CHEMISTRY TESTS	0.00	0.00	0.00	0.00		XXX
80008		X	8 CLINICAL CHEMISTRY TESTS	0.00	0.00	0.00	0.00		XXX
80009		X	9 CLINICAL CHEMISTRY TESTS	0.00	0.00	0.00	0.00		XXX
80010		X	10 CLINICAL CHEMISTRY TESTS	0.00	0.00	0.00	0.00		XXX
80011		X	11 CLINICAL CHEMISTRY TESTS	0.00	0.00	0.00	0.00		XXX
80012		X	12 CLINICAL CHEMISTRY TESTS	0.00	0.00	0.00	0.00		XXX
80016		X	13-16 BLOOD/URINE TESTS	0.00	0.00	0.00	0.00		XXX
80018		X	17-18 BLOOD/URINE TESTS	0.00	0.00	0.00	0.00		XXX
80019		X	19 OR MORE BLOOD/URINE TESTS	0.00	0.00	0.00	0.00		XXX
80031		X	DRUG MONITORING, ONE DRUG	0.00	0.00	0.00	0.00		XXX
80040		X	BLOOD ANTIBIOTIC LEVEL TEST	0.00	0.00	0.00	0.00		XXX
80042		X	ASSAY BLOOD, ANTIMICROBIAL	0.00	0.00	0.00	0.00		XXX
80050		X	GENERAL HEALTH SCREEN PANEL	0.00	0.00	0.00	0.00		XXX
80052		X	PRE-MARITAL PROFILE	0.00	0.00	0.00	0.00		XXX
80053		X	EXECUTIVE PROFILE	0.00	0.00	0.00	0.00		XXX
80055		X	OBSTETRIC PROFILE	0.00	0.00	0.00	0.00		XXX
80056		X	AMENORRHEA PANEL	0.00	0.00	0.00	0.00		XXX
80057		X	MALE ENDOCRINE PANEL	0.00	0.00	0.00	0.00		XXX
80058		X	HEPATIC FUNCTION PANEL	0.00	0.00	0.00	0.00		XXX
80059		X	HEPATITIS PANEL	0.00	0.00	0.00	0.00		XXX
80060		X	HYPERTENSION PANEL	0.00	0.00	0.00	0.00		XXX
80061		X	LIPID PROFILE	0.00	0.00	0.00	0.00		XXX
80062		X	CARDIAC EVALUATION PANEL	0.00	0.00	0.00	0.00		XXX
80063		X	CARDIAC INJURY PANEL	0.00	0.00	0.00	0.00		XXX
80064		X	CARDIAC INJURY PANEL	0.00	0.00	0.00	0.00		XXX
80065		X	METABOLIC PANEL	0.00	0.00	0.00	0.00		XXX
80066		X	MALABSORPTION PANEL	0.00	0.00	0.00	0.00		XXX
80067		X	LUNG FUNCTION PANEL	0.00	0.00	0.00	0.00		XXX
80068		X	LUNG MATURITY PROFILE	0.00	0.00	0.00	0.00		XXX
80070		X	THYROID PANEL	0.00	0.00	0.00	0.00		XXX
80071		X	THYROID PANEL WITH TRH	0.00	0.00	0.00	0.00		XXX
80072		X	ARTHRITIS PANEL	0.00	0.00	0.00	0.00		XXX
80073		X	RENAL PANEL	0.00	0.00	0.00	0.00		XXX
80075		X	PARATHYROID PANEL	0.00	0.00	0.00	0.00		XXX
80080		X	PROSTATIC PANEL	0.00	0.00	0.00	0.00		XXX
80082		X	PANCREATIC PANEL	0.00	0.00	0.00	0.00		XXX
80084		X	PITUITARY PANEL	0.00	0.00	0.00	0.00		XXX
80085		X	MICROCYTIC ANEMIA PANEL	0.00	0.00	0.00	0.00		XXX
80086		X	MACROCYTIC ANEMIA PANEL	0.00	0.00	0.00	0.00		XXX
80088		X	TRANSITION PANEL	0.00	0.00	0.00	0.00		XXX
80089		X	MUSCLE PANEL	0.00	0.00	0.00	0.00		XXX
80090		X	ANTIBODY PANEL	0.00	0.00	0.00	0.00		XXX
80099		X	PANEL, NOT SPECIFIED	0.00	0.00	0.00	0.00		XXX
80500		A	LAB PATHOLOGY CONSULTATION	0.38	0.21	0.01	0.60	2	XXX
80502		A	LAB PATHOLOGY CONSULTATION	1.40	0.34	0.02	1.76	1	XXX
81000		X	URINALYSIS WITH MICROSCOPY	0.00	0.00	0.00	0.00		XXX
81002		X	URINALYSIS WITHOUT SCOPE	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
81005		X	URINALYSIS	0.00	0.00	0.00	0.00		XXX
81007		X	URINE SCREEN FOR BACTERIA	0.00	0.00	0.00	0.00		XXX
81015		X	MICROSCOPIC EXAM OF URINE	0.00	0.00	0.00	0.00		XXX
81099		X	URINALYSIS TEST PROCEDURE	0.00	0.00	0.00	0.00		XXX
82000		X	ASSAY BLOOD ACETALDEHYDE	0.00	0.00	0.00	0.00		XXX
82003		X	ASSAY URINE ACETAMINOPHEN	0.00	0.00	0.00	0.00		XXX
82005		X	ACETOACETIC ACID ASSAY	0.00	0.00	0.00	0.00		XXX
82009		X	TEST FOR ACETONE	0.00	0.00	0.00	0.00		XXX
82010		X	ACETONE ASSAY	0.00	0.00	0.00	0.00		XXX
82011		X	ACETYSALICYLIC ACID ASSAY	0.00	0.00	0.00	0.00		XXX
82012		X	ACETYSALICYLIC ACID TEST	0.00	0.00	0.00	0.00		XXX
82013		X	ACETYLCHOLINESTERASE ASSAY	0.00	0.00	0.00	0.00		XXX
82015		X	URINE ACIDITY ASSAY	0.00	0.00	0.00	0.00		XXX
82024		X	ACTH RADIOIMMUNE ASSAY	0.00	0.00	0.00	0.00		XXX
82030		X	RIA ASSAY, BLOOD ADP & AMP	0.00	0.00	0.00	0.00		XXX
82035		X	ASSAY OF BLOOD ATP	0.00	0.00	0.00	0.00		XXX
82040		X	ASSAY SERUM ALBUMIN	0.00	0.00	0.00	0.00		XXX
82042		X	ASSAY URINE ALBUMIN	0.00	0.00	0.00	0.00		XXX
82055		X	ASSAY BLOOD ETHANOL	0.00	0.00	0.00	0.00		XXX
82060		X	ASSAY BLOOD ETHANOL	0.00	0.00	0.00	0.00		XXX
82065		X	ASSAY URINE ETHANOL	0.00	0.00	0.00	0.00		XXX
82070		X	ASSAY URINE ETHANOL	0.00	0.00	0.00	0.00		XXX
82072		X	ASSAY OF ETHANOL	0.00	0.00	0.00	0.00		XXX
82075		X	ASSAY BREATH ETHANOL	0.00	0.00	0.00	0.00		XXX
82076		X	ASSAY OF ISOPROPYL ALCOHOL	0.00	0.00	0.00	0.00		XXX
82078		X	ASSAY OF METHANOL	0.00	0.00	0.00	0.00		XXX
82085		X	ASSAY OF BLOOD ALDOLASE	0.00	0.00	0.00	0.00		XXX
82086		X	ASSAY OF BLOOD ALDOLASE	0.00	0.00	0.00	0.00		XXX
82087		X	RADIOASSAY OF ALDOSTERONE	0.00	0.00	0.00	0.00		XXX
82088		X	RIA ASSAY, BLOOD ALDOSTERONE	0.00	0.00	0.00	0.00		XXX
82089		X	RIA ASSAY, URINE ALDOSTERONE	0.00	0.00	0.00	0.00		XXX
82091		X	ALDOSTERONE SALINE TEST	0.00	0.00	0.00	0.00		XXX
82095		X	TEST FOR ALKALOIDS	0.00	0.00	0.00	0.00		XXX
82096		X	ASSAY OF ALKALOIDS	0.00	0.00	0.00	0.00		XXX
82100		X	TEST FOR URINE ALKALOIDS	0.00	0.00	0.00	0.00		XXX
82101		X	ASSAY OF URINE ALKALOIDS	0.00	0.00	0.00	0.00		XXX
82108		X	ASSAY BLOOD, ALUMINUM	0.00	0.00	0.00	0.00		XXX
82112		X	ASSAY OF AMIKACIN	0.00	0.00	0.00	0.00		XXX
82126		X	AMINO ACID NITROGEN ASSAY	0.00	0.00	0.00	0.00		XXX
82128		X	TEST FOR AMINO ACIDS	0.00	0.00	0.00	0.00		XXX
82130		X	AMINO ACIDS ANALYSIS	0.00	0.00	0.00	0.00		XXX
82134		X	ASSAY OF AMINOHIPPURATE	0.00	0.00	0.00	0.00		XXX
82135		X	ASSAY, AMINOLEVULINIC ACID	0.00	0.00	0.00	0.00		XXX
82137		X	ASSAY OF AMINOPHYLLINE	0.00	0.00	0.00	0.00		XXX
82138		X	ASSAY OF AMITRIPTYLINE	0.00	0.00	0.00	0.00		XXX
82140		X	ASSAY OF BLOOD AMMONIA	0.00	0.00	0.00	0.00		XXX
82141		X	ASSAY OF URINE AMMONIA	0.00	0.00	0.00	0.00		XXX
82142		X	AMMONIUM CHLORIDE LOAD TEST	0.00	0.00	0.00	0.00		XXX
82143		X	AMNIOTIC FLUID SCAN	0.00	0.00	0.00	0.00		XXX
82145		X	ASSAY OF AMPHETAMINES	0.00	0.00	0.00	0.00		XXX
82150		X	ASSAY OF SERUM AMYLASE	0.00	0.00	0.00	0.00		XXX
82156		X	ASSAY OF URINE AMYLASE	0.00	0.00	0.00	0.00		XXX
82157		X	RIA ASSAY OF ANDROSTENEDIONE	0.00	0.00	0.00	0.00		XXX
82159		X	ASSAY OF ANDROSTERONE	0.00	0.00	0.00	0.00		XXX
82160		X	RIA ASSAY ANDROSTERONE	0.00	0.00	0.00	0.00		XXX
82163		X	RIA ASSAY OF ANGIOTENSIN II	0.00	0.00	0.00	0.00		XXX
82164		X	ANGIOTENSIN ENZYME TEST	0.00	0.00	0.00	0.00		XXX
82165		X	ASSAY OF ANILINE	0.00	0.00	0.00	0.00		XXX
82168		X	ASSAY OF ANTIHISTAMINES	0.00	0.00	0.00	0.00		XXX
82170		X	ASSAY OF URINE ANTIMONY	0.00	0.00	0.00	0.00		XXX
82172		X	APOLIPOPROTEIN IMMUNOASSAY	0.00	0.00	0.00	0.00		XXX
82173		X	ARGININE TOLERANCE TEST	0.00	0.00	0.00	0.00		XXX
82175		X	ASSAY OF ARSENIC	0.00	0.00	0.00	0.00		XXX
82180		X	ASSAY OF ASCORBIC ACID	0.00	0.00	0.00	0.00		XXX
82205		X	ASSAY OF BARBITURATES	0.00	0.00	0.00	0.00		XXX
82210		X	ASSAY/IDENTIFY BARBITURATES	0.00	0.00	0.00	0.00		XXX
82225		X	ASSAY OF BARIUM	0.00	0.00	0.00	0.00		XXX
82230		X	ASSAY BERYLLIUM IN URINE	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
82231		X	RIA ASSAY URINE PROTEIN	0.00	0.00	0.00	0.00		XXX
82232		X	RIA ASSAY SERUM PROTEIN	0.00	0.00	0.00	0.00		XXX
82235		X	BICARBONATE EXCRETION, URINE	0.00	0.00	0.00	0.00		XXX
82236		X	BICARBONATE LOADING TEST	0.00	0.00	0.00	0.00		XXX
82240		X	ASSAY BILE ACIDS IN BLOOD	0.00	0.00	0.00	0.00		XXX
82245		X	URINE ASSAY, BILE PIGMENTS	0.00	0.00	0.00	0.00		XXX
82250		X	ASSAY BLOOD BILIRUBIN	0.00	0.00	0.00	0.00		XXX
82251		X	ASSAY BLOOD BILIRUBIN	0.00	0.00	0.00	0.00		XXX
82252		X	FECAL BILIRUBIN TEST	0.00	0.00	0.00	0.00		XXX
82260		X	ASSAY URINE BILIRUBIN	0.00	0.00	0.00	0.00		XXX
82265		X	ASSAY AMNIOTIC BILIRUBIN	0.00	0.00	0.00	0.00		XXX
82268		X	ASSAY OF BISMUTH	0.00	0.00	0.00	0.00		XXX
82270		X	TEST FECES FOR BLOOD	0.00	0.00	0.00	0.00		XXX
82273		X	TEST FOR GASTRIC BLOOD	0.00	0.00	0.00	0.00		XXX
82280		X	ASSAY BORIC ACID IN BLOOD	0.00	0.00	0.00	0.00		XXX
82285		X	ASSAY BORIC ACID IN URINE	0.00	0.00	0.00	0.00		XXX
82286		X	ASSAY OF BRADYKININ	0.00	0.00	0.00	0.00		XXX
82290		X	ASSAY BROMIDES IN BLOOD	0.00	0.00	0.00	0.00		XXX
82291		X	ASSAY BROMIDES IN URINE	0.00	0.00	0.00	0.00		XXX
82300		X	ASSAY CADMIUM IN URINE	0.00	0.00	0.00	0.00		XXX
82305		X	ASSAY OF CAFFEINE	0.00	0.00	0.00	0.00		XXX
82306		X	ASSAY OF VITAMIN D	0.00	0.00	0.00	0.00		XXX
82307		X	RIA ASSAY OF VITAMIN D	0.00	0.00	0.00	0.00		XXX
82308		X	RIA ASSAY OF CALCITONIN	0.00	0.00	0.00	0.00		XXX
82310		X	ASSAY CALCIUM IN BLOOD	0.00	0.00	0.00	0.00		XXX
82315		X	ASSAY CALCIUM IN BLOOD	0.00	0.00	0.00	0.00		XXX
82320		X	ASSAY CALCIUM IN BLOOD	0.00	0.00	0.00	0.00		XXX
82325		X	ASSAY CALCIUM IN BLOOD	0.00	0.00	0.00	0.00		XXX
82330		X	ASSAY CALCIUM IN BLOOD	0.00	0.00	0.00	0.00		XXX
82331		X	CALCIUM INFUSION TEST	0.00	0.00	0.00	0.00		XXX
82335		X	ASSAY CALCIUM IN URINE	0.00	0.00	0.00	0.00		XXX
82340		X	ASSAY CALCIUM IN URINE	0.00	0.00	0.00	0.00		XXX
82355		X	CALCULUS (STONE) ANALYSIS	0.00	0.00	0.00	0.00		XXX
82360		X	CALCULUS (STONE) ASSAY	0.00	0.00	0.00	0.00		XXX
82365		X	CALCULUS (STONE) ASSAY	0.00	0.00	0.00	0.00		XXX
82370		X	X-RAY ASSAY, CALCULUS (STONE)	0.00	0.00	0.00	0.00		XXX
82372		X	ASSAY SERUM CARBAMAZEPINE	0.00	0.00	0.00	0.00		XXX
82374		X	ASSAY BLOOD CARBON DIOXIDE	0.00	0.00	0.00	0.00		XXX
82375		X	ASSAY BLOOD CARBON MONOXIDE	0.00	0.00	0.00	0.00		XXX
82376		X	TEST FOR CARBON MONOXIDE	0.00	0.00	0.00	0.00		XXX
82380		X	ASSAY BLOOD CAROTENE	0.00	0.00	0.00	0.00		XXX
82382		X	ASSAY URINE CATECHOLAMINES	0.00	0.00	0.00	0.00		XXX
82383		X	ASSAY BLOOD CATECHOLAMINES	0.00	0.00	0.00	0.00		XXX
82384		X	ASSAY THREE CATECHOLAMINES	0.00	0.00	0.00	0.00		XXX
82390		X	ASSAY BLOOD CERULOPLASMIN	0.00	0.00	0.00	0.00		XXX
82400		X	ASSAY BLOOD CHLORAL HYDRATE	0.00	0.00	0.00	0.00		XXX
82405		X	ASSAY URINE CHLORAL HYDRATE	0.00	0.00	0.00	0.00		XXX
82415		X	ASSAY BLOOD CHLORAMPHENICOL	0.00	0.00	0.00	0.00		XXX
82418		X	ASSAY OF CHLORAZEPATE	0.00	0.00	0.00	0.00		XXX
82420		X	ASSAY BLOOD CHLORDIAZEPOXIDE	0.00	0.00	0.00	0.00		XXX
82425		X	ASSAY URINE CHLORDIAZEPOXIDE	0.00	0.00	0.00	0.00		XXX
82435		X	ASSAY BLOOD CHLORIDES	0.00	0.00	0.00	0.00		XXX
82436		X	ASSAY URINE CHLORIDES	0.00	0.00	0.00	0.00		XXX
82437		X	ASSAY SWEAT CHLORIDES	0.00	0.00	0.00	0.00		XXX
82438		X	ASSAY SPINAL FLUID CHLORIDES	0.00	0.00	0.00	0.00		XXX
82441		X	TEST FOR CHLOROHYDROCARBONS	0.00	0.00	0.00	0.00		XXX
82443		X	ASSAY OF THIAZIDE	0.00	0.00	0.00	0.00		XXX
82465		X	ASSAY SERUM CHOLESTEROL	0.00	0.00	0.00	0.00		XXX
82470		X	ASSAY SERUM CHOLESTEROL	0.00	0.00	0.00	0.00		XXX
82480		X	ASSAY SERUM CHOLINESTERASE	0.00	0.00	0.00	0.00		XXX
82482		X	ASSAY RBC CHOLINESTERASE	0.00	0.00	0.00	0.00		XXX
82484		X	ASSAY BLOOD CHOLINESTERASE	0.00	0.00	0.00	0.00		XXX
82485		X	ASSAY CHONDROITIN SULFATE	0.00	0.00	0.00	0.00		XXX
82486		X	GAS/LIQUID CHROMATOGRAPHY	0.00	0.00	0.00	0.00		XXX
82487		X	PAPER CHROMATOGRAPHY	0.00	0.00	0.00	0.00		XXX
82488		X	PAPER CHROMATOGRAPHY	0.00	0.00	0.00	0.00		XXX
82489		X	THIN LAYER CHROMATOGRAPHY	0.00	0.00	0.00	0.00		XXX
82495		X	ASSAY URINE CHROMIUM	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
82507		X	ASSAY CITRATE	0.00	0.00	0.00	0.00		XXX
82512		X	ASSAY OF CLONAZEPAM	0.00	0.00	0.00	0.00		XXX
82520		X	ASSAY FOR COCAINE	0.00	0.00	0.00	0.00		XXX
82525		X	ASSAY BLOOD COPPER	0.00	0.00	0.00	0.00		XXX
82526		X	ASSAY URINE COPPER	0.00	0.00	0.00	0.00		XXX
82528		X	RIA ASSAY CORTICOSTERONE	0.00	0.00	0.00	0.00		XXX
82529		X	ASSAY OF CORTISOL	0.00	0.00	0.00	0.00		XXX
82531		X	ASSAY PLASMA CORTISOL	0.00	0.00	0.00	0.00		XXX
82532		X	ASSAY URINE CORTISOL	0.00	0.00	0.00	0.00		XXX
82533		X	RIA ASSAY PLASMA CORTISOL	0.00	0.00	0.00	0.00		XXX
82534		X	RIA ASSAY URINE CORTISOL	0.00	0.00	0.00	0.00		XXX
82536		X	CORTISOL TEST AFTER ACTH	0.00	0.00	0.00	0.00		XXX
82537		X	CORTISOL TEST AFTER ACTH	0.00	0.00	0.00	0.00		XXX
82538		X	CORTISOL AFTER METYRAPONE	0.00	0.00	0.00	0.00		XXX
82539		X	CORTISOL AFTER DEXAMETHASONE	0.00	0.00	0.00	0.00		XXX
82540		X	ASSAY BLOOD CREATINE	0.00	0.00	0.00	0.00		XXX
82545		X	ASSAY URINE CREATINE	0.00	0.00	0.00	0.00		XXX
82546		X	ASSAY CREATINE & CREATININE	0.00	0.00	0.00	0.00		XXX
82550		X	ASSAY CPK IN BLOOD	0.00	0.00	0.00	0.00		XXX
82552		X	ASSAY CPK IN BLOOD	0.00	0.00	0.00	0.00		XXX
82555		X	ASSAY CPK IN BLOOD	0.00	0.00	0.00	0.00		XXX
82565		X	ASSAY BLOOD CREATININE	0.00	0.00	0.00	0.00		XXX
82570		X	ASSAY URINE CREATININE	0.00	0.00	0.00	0.00		XXX
82575		X	CREATININE CLEARANCE TEST	0.00	0.00	0.00	0.00		XXX
82585		X	ASSAY BLOOD CRYOFIBRINOGEN	0.00	0.00	0.00	0.00		XXX
82595		X	ASSAY BLOOD CRYOGLOBULIN	0.00	0.00	0.00	0.00		XXX
82600		X	ASSAY BLOOD CYANIDE	0.00	0.00	0.00	0.00		XXX
82601		X	ASSAY TISSUE CYANIDE	0.00	0.00	0.00	0.00		XXX
82606		X	BIOASSAY FOR VITAMIN B-12	0.00	0.00	0.00	0.00		XXX
82607		X	RIA ASSAY FOR VITAMIN B-12	0.00	0.00	0.00	0.00		XXX
82608		X	B-12 BINDING CAPACITY	0.00	0.00	0.00	0.00		XXX
82614		X	TEST FOR BLOOD CYSTINE	0.00	0.00	0.00	0.00		XXX
82615		X	TEST FOR URINE CYSTINES	0.00	0.00	0.00	0.00		XXX
82620		X	ASSAY URINE CYSTINES	0.00	0.00	0.00	0.00		XXX
82624		X	CYSTINE AMINOPEPTIDASE ASSAY	0.00	0.00	0.00	0.00		XXX
82626		X	DEHYDROEPIANDROSTERONE, RIA	0.00	0.00	0.00	0.00		XXX
82628		X	ASSAY OF DESIPRAMINE	0.00	0.00	0.00	0.00		XXX
82633		X	DESOXYCORTICOSTERONE, RIA	0.00	0.00	0.00	0.00		XXX
82634		X	DEOXYCORTISOL, RIA	0.00	0.00	0.00	0.00		XXX
82635		X	ASSAY OF DIACETIC ACID	0.00	0.00	0.00	0.00		XXX
82636		X	ASSAY OF DIAZEPAM	0.00	0.00	0.00	0.00		XXX
82638		X	ASSAY DIBUCAINE NUMBER	0.00	0.00	0.00	0.00		XXX
82639		X	ASSAY FOR DICUMAROL	0.00	0.00	0.00	0.00		XXX
82640		X	RIA FOR BLOOD DIGITOXIN	0.00	0.00	0.00	0.00		XXX
82641		X	ASSAY URINE FOR DIGITOXIN	0.00	0.00	0.00	0.00		XXX
82643		X	RIA ASSAY FOR DIGOXIN	0.00	0.00	0.00	0.00		XXX
82646		X	ASSAY OF DIHYDROCODEINONE	0.00	0.00	0.00	0.00		XXX
82649		X	ASSAY OF DIHYDROMORPHINONE	0.00	0.00	0.00	0.00		XXX
82651		X	DIHYDROTESTOSTERONE ASSAY	0.00	0.00	0.00	0.00		XXX
82652		X	ASSAY, DIHYDROXYVITAMIN D	0.00	0.00	0.00	0.00		XXX
82654		X	ASSAY OF DIMETHADIONE	0.00	0.00	0.00	0.00		XXX
82656		X	ASSAY OF DOXEPIN	0.00	0.00	0.00	0.00		XXX
82660		X	TEST FOR DRUGS	0.00	0.00	0.00	0.00		XXX
82664		X	ELECTROPHORETIC TEST	0.00	0.00	0.00	0.00		XXX
82666		X	EPIANDROSTERONE ASSAY	0.00	0.00	0.00	0.00		XXX
82668		X	ERYTHROPOIETIN BIOASSAY	0.00	0.00	0.00	0.00		XXX
82670		X	RIA ASSAY OF ESTRADIOL	0.00	0.00	0.00	0.00		XXX
82671		X	ESTROGENS ASSAY	0.00	0.00	0.00	0.00		XXX
82672		X	ESTROGEN ASSAY	0.00	0.00	0.00	0.00		XXX
82673		X	ESTRIOL ASSAY	0.00	0.00	0.00	0.00		XXX
82674		X	ESTRIOL ASSAY	0.00	0.00	0.00	0.00		XXX
82676		X	ASSAY ESTRIOL	0.00	0.00	0.00	0.00		XXX
82677		X	RIA ASSAY OF ESTRIOL	0.00	0.00	0.00	0.00		XXX
82678		X	ASSAY ESTRONE	0.00	0.00	0.00	0.00		XXX
82679		X	RIA ASSAY OF ESTRONE	0.00	0.00	0.00	0.00		XXX
82690		X	ASSAY BLOOD ETHCHLORVYNOL	0.00	0.00	0.00	0.00		XXX
82691		X	ASSAY URINE ETHCHLORVYNOL	0.00	0.00	0.00	0.00		XXX
82692		X	ASSAY OF ETHOSUXIMIDE	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPs*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
82694		X	ASSAY OF ETIOCHOLANOLONE	0.00	0.00	0.00	0.00		XXX
82696		X	RIA ASSAY OF ETIOCHOLANOLONE	0.00	0.00	0.00	0.00		XXX
82705		X	FATS/LIPIDS, FECES, SCREENING	0.00	0.00	0.00	0.00		XXX
82710		X	FATS/LIPIDS, FECES, ASSAY	0.00	0.00	0.00	0.00		XXX
82715		X	FECAL FAT ASSAY	0.00	0.00	0.00	0.00		XXX
82720		X	ASSAY BLOOD FATTY ACID, ESTER	0.00	0.00	0.00	0.00		XXX
82725		X	ASSAY BLOOD FATTY ACIDS	0.00	0.00	0.00	0.00		XXX
82727		X	FERRIC CHLORIDE, ASSAY, URINE	0.00	0.00	0.00	0.00		XXX
82728		X	ASSAY FERRITIN	0.00	0.00	0.00	0.00		XXX
82730		X	ASSAY BLOOD FIBRINOGEN	0.00	0.00	0.00	0.00		XXX
82735		X	ASSAY BLOOD FLUORIDE	0.00	0.00	0.00	0.00		XXX
82740		X	ASSAY URINE FLUORIDE	0.00	0.00	0.00	0.00		XXX
82741		X	ASSAY OF FLUCYTOSINE	0.00	0.00	0.00	0.00		XXX
82742		X	ASSAY OF FLURAZEPAM	0.00	0.00	0.00	0.00		XXX
82745		X	BLOOD FOLIC ACID BIOASSAY	0.00	0.00	0.00	0.00		XXX
82746		X	BLOOD FOLIC ACID RIA	0.00	0.00	0.00	0.00		XXX
82750		X	ASSAY FIGLU ACID IN URINE	0.00	0.00	0.00	0.00		XXX
82755		X	FREE RADICAL ASSAY FOR DRUGS	0.00	0.00	0.00	0.00		XXX
82756		X	FREE THYROXINE INDEX (T-7)	0.00	0.00	0.00	0.00		XXX
82757		X	ASSAY SEMEN FRUCTOSE	0.00	0.00	0.00	0.00		XXX
82759		X	RBC GALACTOKINASE ASSAY	0.00	0.00	0.00	0.00		XXX
82760		X	ASSAY BLOOD GALACTOSE	0.00	0.00	0.00	0.00		XXX
82763		X	GALACTOSE TOLERANCE TEST	0.00	0.00	0.00	0.00		XXX
82765		X	ASSAY URINE GALACTOSE	0.00	0.00	0.00	0.00		XXX
82775		X	ASSAY GALACTOSE TRANSFERASE	0.00	0.00	0.00	0.00		XXX
82776		X	GALACTOSE TRANSFERASE TEST	0.00	0.00	0.00	0.00		XXX
82780		X	ASSAY OF GALLIUM	0.00	0.00	0.00	0.00		XXX
82784		X	ASSAY GAMMAGLOBULIN A/D/G/M	0.00	0.00	0.00	0.00		XXX
82785		X	ASSAY, GAMMAGLOBULIN E	0.00	0.00	0.00	0.00		XXX
82786		X	ASSAY OF GAMMAGLOBULIN	0.00	0.00	0.00	0.00		XXX
82790		X	BLOOD OXYGEN SATURATION	0.00	0.00	0.00	0.00		XXX
82791		X	BLOOD OXYGEN SATURATION	0.00	0.00	0.00	0.00		XXX
82792		X	BLOOD OXYGEN SATURATION	0.00	0.00	0.00	0.00		XXX
82793		X	BLOOD OXYGEN SATURATION	0.00	0.00	0.00	0.00		XXX
82795		X	BLOOD OXYGEN SATURATION	0.00	0.00	0.00	0.00		XXX
82800		X	BLOOD PH	0.00	0.00	0.00	0.00		XXX
82801		X	BLOOD GASES: PCO2	0.00	0.00	0.00	0.00		XXX
82802		X	BLOOD GASES: PH & PCO2	0.00	0.00	0.00	0.00		XXX
82803		X	BLOOD GASES: PH, PO2 & PCO2	0.00	0.00	0.00	0.00		XXX
82804		X	BLOOD GASES: ELECTRODE PO2	0.00	0.00	0.00	0.00		XXX
82812		X	BLOOD GASES: MANOMETRY PO2	0.00	0.00	0.00	0.00		XXX
82817		X	BLOOD GASES: PH, PCO2	0.00	0.00	0.00	0.00		XXX
82926		X	ASSAY GASTRIC ACID	0.00	0.00	0.00	0.00		XXX
82927		X	ADDED ASSAY GASTRIC ACID	0.00	0.00	0.00	0.00		XXX
82928		X	ASSAY GASTRIC ACID	0.00	0.00	0.00	0.00		XXX
82929		X	ADDED ASSAY GASTRIC ACID	0.00	0.00	0.00	0.00		XXX
82931		X	TITRATE GASTRIC PH, 1 SAMPLE	0.00	0.00	0.00	0.00		XXX
82932		X	TITRATE GASTRIC PH, EACH SPEC	0.00	0.00	0.00	0.00		XXX
82938		X	SERUM GASTRIN TEST	0.00	0.00	0.00	0.00		XXX
82941		X	RIA ASSAY OF GASTRIN	0.00	0.00	0.00	0.00		XXX
82942		X	ASSAY SERUM GLOBULIN	0.00	0.00	0.00	0.00		XXX
82943		X	RIA ASSAY OF GLUCAGON	0.00	0.00	0.00	0.00		XXX
82944		X	ASSAY GLUCOSAMINE	0.00	0.00	0.00	0.00		XXX
82946		X	GLUCAGON TOLERANCE TEST	0.00	0.00	0.00	0.00		XXX
82947		X	ASSAY BODY FLUID, GLUCOSE	0.00	0.00	0.00	0.00		XXX
82948		X	STICK ASSAY OF BLOOD GLUCOSE	0.00	0.00	0.00	0.00		XXX
82949		X	FERMENT ASSAY OF GLUCOSE	0.00	0.00	0.00	0.00		XXX
82950		X	GLUCOSE TEST	0.00	0.00	0.00	0.00		XXX
82951		X	GLUCOSE TOLERANCE TEST (GTT)	0.00	0.00	0.00	0.00		XXX
82952		X	GTT-ADDED SAMPLES	0.00	0.00	0.00	0.00		XXX
82953		X	GLUCOSE-TOLBUTAMIDE TEST	0.00	0.00	0.00	0.00		XXX
82954		X	ASSAY URINE GLUCOSE	0.00	0.00	0.00	0.00		XXX
82955		X	ASSAY G6PD ENZYME	0.00	0.00	0.00	0.00		XXX
82960		X	TEST FOR G6PD ENZYME	0.00	0.00	0.00	0.00		XXX
82961		X	IV GLUCOSE TOLERANCE TEST	0.00	0.00	0.00	0.00		XXX
82963		X	GLUCOSIDASE ASSAY	0.00	0.00	0.00	0.00		XXX
82965		X	ASSAY BLOOD GDH ENZYME	0.00	0.00	0.00	0.00		XXX
82975		X	ASSAY SPINAL FLUID GLUTAMINE	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
82977		X	ASSAY OF GGT ENZYME	0.00	0.00	0.00	0.00		XXX
82978		X	GLUTATHIONE ASSAY	0.00	0.00	0.00	0.00		XXX
82979		X	ASSAY RBC GLUTATHIONE ENZYME	0.00	0.00	0.00	0.00		XXX
82980		X	ASSAY OF GLUTETHIMIDE	0.00	0.00	0.00	0.00		XXX
82985		X	GLYCOPROTEIN ELECTROPHORESIS	0.00	0.00	0.00	0.00		XXX
82995		X	ASSAY BLOOD FOR GOLD	0.00	0.00	0.00	0.00		XXX
83000		X	PITUITARY GONADOTROPIN ASSAY	0.00	0.00	0.00	0.00		XXX
83001		X	PITUITARY GONADOTROPIN RIA	0.00	0.00	0.00	0.00		XXX
83002		X	PITUITARY GONADOTROPINS RIA	0.00	0.00	0.00	0.00		XXX
83003		X	RIA ASSAY GROWTH HORMONE	0.00	0.00	0.00	0.00		XXX
83004		X	GROWTH HORMONE AFTER GTT	0.00	0.00	0.00	0.00		XXX
83008		X	RIA ASSAY GUANOSINE	0.00	0.00	0.00	0.00		XXX
83010		X	CHEM ASSAY HAPTOGLOBIN	0.00	0.00	0.00	0.00		XXX
83011		X	ELP ASSAY HAPTOGLOBIN	0.00	0.00	0.00	0.00		XXX
83012		X	ELP ASSAY HAPTOGLOBINS	0.00	0.00	0.00	0.00		XXX
83015		X	HEAVY METAL SCREENING	0.00	0.00	0.00	0.00		XXX
83018		X	CHROMATOGRAPH SCREEN, METALS	0.00	0.00	0.00	0.00		XXX
83020		X	ASSAY HEMOGLOBIN	0.00	0.00	0.00	0.00		XXX
83020	26	A	ASSAY HEMOGLOBIN	0.38	0.21	0.01	0.60	2	XXX
83030		X	FETAL HEMOGLOBIN ASSAY	0.00	0.00	0.00	0.00		XXX
83033		X	FETAL FECAL HEMOGLOBIN ASSAY	0.00	0.00	0.00	0.00		XXX
83036		X	GLYCOSYLATED HEMOGLOBIN TEST	0.00	0.00	0.00	0.00		XXX
83040		X	BLOOD METHEMOGLOBIN ASSAY	0.00	0.00	0.00	0.00		XXX
83045		X	BLOOD METHEMOGLOBIN TEST	0.00	0.00	0.00	0.00		XXX
83050		X	BLOOD METHEMOGLOBIN ASSAY	0.00	0.00	0.00	0.00		XXX
83051		X	ASSAY PLASMA HEMOGLOBIN	0.00	0.00	0.00	0.00		XXX
83052		X	SICKLE HEMOGLOBIN TEST	0.00	0.00	0.00	0.00		XXX
83053		X	ASSAY HEMOGLOBIN SOLUBILITY	0.00	0.00	0.00	0.00		XXX
83055		X	BLOOD SULFHEMOGLOBIN TEST	0.00	0.00	0.00	0.00		XXX
83060		X	BLOOD SULFHEMOGLOBIN ASSAY	0.00	0.00	0.00	0.00		XXX
83065		X	HEMOGLOBIN HEAT ASSAY	0.00	0.00	0.00	0.00		XXX
83068		X	HEMOGLOBIN STABILITY SCREEN	0.00	0.00	0.00	0.00		XXX
83069		X	ASSAY URINE HEMOGLOBIN	0.00	0.00	0.00	0.00		XXX
83070		X	ASSAY URINE HEMOSIDERIN	0.00	0.00	0.00	0.00		XXX
83071		X	RIA ASSAY OF HEMOSIDERIN	0.00	0.00	0.00	0.00		XXX
83086		X	TEST BLOOD FOR HISTIDINE	0.00	0.00	0.00	0.00		XXX
83087		X	TEST URINE FOR HISTIDINE	0.00	0.00	0.00	0.00		XXX
83088		X	ASSAY HISTAMINE	0.00	0.00	0.00	0.00		XXX
83093		X	BLOOD HOMOGENITISIC ACID TEST	0.00	0.00	0.00	0.00		XXX
83094		X	URINE HOMOGENITISIC ACID TEST	0.00	0.00	0.00	0.00		XXX
83095		X	URINE HOMOGENITISICACID ASSAY	0.00	0.00	0.00	0.00		XXX
83150		X	ASSAY URINE FOR HVA	0.00	0.00	0.00	0.00		XXX
83485		X	UV-ASSAY BLOOD HBD ENZYME	0.00	0.00	0.00	0.00		XXX
83486		X	ASSAY BLOOD HBD ENZYME	0.00	0.00	0.00	0.00		XXX
83491		X	RIA ASSAY OF CORTICOSTEROIDS	0.00	0.00	0.00	0.00		XXX
83492		X	GLC-ASSAY CORTICOSTEROIDS	0.00	0.00	0.00	0.00		XXX
83493		X	ASSAY BLOOD CORTICOSTEROIDS	0.00	0.00	0.00	0.00		XXX
83494		X	ASSAY BLOOD CORTICOSTEROIDS	0.00	0.00	0.00	0.00		XXX
83495		X	ASSAY URINE CORTICOSTEROIDS	0.00	0.00	0.00	0.00		XXX
83496		X	ASSAY URINE CORTICOSTEROIDS	0.00	0.00	0.00	0.00		XXX
83497		X	ASSAY URINE 5-HIAA	0.00	0.00	0.00	0.00		XXX
83498		X	RIA ASSAY OF PROGESTERONE	0.00	0.00	0.00	0.00		XXX
83499		X	ASSAY OF PROGESTERONE	0.00	0.00	0.00	0.00		XXX
83500		X	ASSAY URINE HYDROXYPROLINE	0.00	0.00	0.00	0.00		XXX
83505		X	ASSAY URINE HYDROXYPROLINE	0.00	0.00	0.00	0.00		XXX
83510		X	ASSAY URINE HYDROXYPROLINE	0.00	0.00	0.00	0.00		XXX
83523		X	ASSAY OF IMIPRAMINE	0.00	0.00	0.00	0.00		XXX
83524		X	ASSAY URINE INDICAN	0.00	0.00	0.00	0.00		XXX
83525		X	RIA ASSAY OF INSULIN	0.00	0.00	0.00	0.00		XXX
83526		X	INSULIN TOLERANCE TEST	0.00	0.00	0.00	0.00		XXX
83528		X	ASSAY INTRINSIC FACTOR LEVEL	0.00	0.00	0.00	0.00		XXX
83530		X	INULIN CLEARANCE TEST	0.00	0.00	0.00	0.00		XXX
83540		X	ASSAY SERUM IRON	0.00	0.00	0.00	0.00		XXX
83545		X	AUTO-ASSAY SERUM IRON	0.00	0.00	0.00	0.00		XXX
83546		X	RADIO-ASSAY SERUM IRON	0.00	0.00	0.00	0.00		XXX
83550		X	SERUM IRON BINDING TEST	0.00	0.00	0.00	0.00		XXX
83555		X	SERUM IRON BINDING,AUTO-TEST	0.00	0.00	0.00	0.00		XXX
83565		X	SERUM RADIO-IRON BINDING	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
83570		X	UV-ASSAY BLOOD IDH ENZYME	0.00	0.00	0.00	0.00		XXX
83571		X	ASSAY BLOOD IDH ENZYME	0.00	0.00	0.00	0.00		XXX
83576		X	ASSAY OF INH	0.00	0.00	0.00	0.00		XXX
83578		X	ASSAY OF KANAMYCIN	0.00	0.00	0.00	0.00		XXX
83582		X	ASSAY URINE 17-KGS	0.00	0.00	0.00	0.00		XXX
83583		X	ASSAY URINE KGS RATIO	0.00	0.00	0.00	0.00		XXX
83584		X	ASSAY KETOGLUTARATE	0.00	0.00	0.00	0.00		XXX
83586		X	ASSAY BLOOD 17-KETOSTEROIDS	0.00	0.00	0.00	0.00		XXX
83587		X	ASSAY BLOOD 17-KETOSTEROIDS	0.00	0.00	0.00	0.00		XXX
83588		X	RIA ASSAY 17-KETOSTEROIDS	0.00	0.00	0.00	0.00		XXX
83589		X	ASSAY URINE 17-KETOSTEROIDS	0.00	0.00	0.00	0.00		XXX
83590		X	ASSAY URINE 17-KETOSTEROIDS	0.00	0.00	0.00	0.00		XXX
83593		X	CHROMATOGRAPH KETOSTEROIDS	0.00	0.00	0.00	0.00		XXX
83597		X	URINE KETOSTEROID RATIO	0.00	0.00	0.00	0.00		XXX
83599		X	RIA ASSAY 17-OH KETOSTEROIDS	0.00	0.00	0.00	0.00		XXX
83600		X	ASSAY KYNURENIC ACID	0.00	0.00	0.00	0.00		XXX
83605		X	LACTIC ACID ASSAY	0.00	0.00	0.00	0.00		XXX
83610		X	RIA ASSAY LDH ENZYME	0.00	0.00	0.00	0.00		XXX
83615		X	UV-ASSAY BLOOD LDH ENZYME	0.00	0.00	0.00	0.00		XXX
83620		X	ASSAY BLOOD LDH ENZYME	0.00	0.00	0.00	0.00		XXX
83624		X	BLOOD LDH ENZYME TEST	0.00	0.00	0.00	0.00		XXX
83625		X	ASSAY BLOOD LDH ENZYMES	0.00	0.00	0.00	0.00		XXX
83626		X	ASSAY BLOOD LDH ENZYMES	0.00	0.00	0.00	0.00		XXX
83628		X	ASSAY LIVER LDH ENZYME	0.00	0.00	0.00	0.00		XXX
83629		X	ASSAY URINE LDH ENZYME	0.00	0.00	0.00	0.00		XXX
83631		X	ASSAY CSF LDH ENZYME	0.00	0.00	0.00	0.00		XXX
83632		X	RIA PLACENTAL LACTOGEN	0.00	0.00	0.00	0.00		XXX
83633		X	TEST URINE FOR LACTOSE	0.00	0.00	0.00	0.00		XXX
83634		X	ASSAY URINE FOR LACTOSE	0.00	0.00	0.00	0.00		XXX
83645		X	TEST BLOOD FOR LEAD	0.00	0.00	0.00	0.00		XXX
83650		X	TEST URINE FOR LEAD	0.00	0.00	0.00	0.00		XXX
83655		X	ASSAY BLOOD FOR LEAD	0.00	0.00	0.00	0.00		XXX
83660		X	ASSAY URINE FOR LEAD	0.00	0.00	0.00	0.00		XXX
83661		X	ASSAY AMNIOTIC L/S RATIO	0.00	0.00	0.00	0.00		XXX
83670		X	UV-ASSAY BLOOD LAP ENZYME	0.00	0.00	0.00	0.00		XXX
83675		X	ASSAY BLOOD LAP ENZYME	0.00	0.00	0.00	0.00		XXX
83680		X	ASSAY URINE LAP ENZYME	0.00	0.00	0.00	0.00		XXX
83681		X	LEUCINE TOLERANCE TEST	0.00	0.00	0.00	0.00		XXX
83685		X	ASSAY FOR LIDOCAINE	0.00	0.00	0.00	0.00		XXX
83690		X	ASSAY BLOOD LIPASE	0.00	0.00	0.00	0.00		XXX
83700		X	ASSAY BLOOD LIPIDS	0.00	0.00	0.00	0.00		XXX
83705		X	ASSAY BLOOD LIPID GROUPS	0.00	0.00	0.00	0.00		XXX
83715		X	ASSAY BLOOD LIPOPROTEINS	0.00	0.00	0.00	0.00		XXX
83717		X	ASSAY BLOOD LIPOPROTEINS	0.00	0.00	0.00	0.00		XXX
83718		X	BLOOD LIPOPROTEIN ASSAY	0.00	0.00	0.00	0.00		XXX
83719		X	BLOOD LIPOPROTEIN ASSAY	0.00	0.00	0.00	0.00		XXX
83720		X	BLOOD LIPOPROTEIN ASSAY	0.00	0.00	0.00	0.00		XXX
83725		X	ASSAY BLOOD LITHIUM	0.00	0.00	0.00	0.00		XXX
83727		X	LRH HORMONE ASSAY, RIA	0.00	0.00	0.00	0.00		XXX
83728		X	RIA ASSAY OF LSD	0.00	0.00	0.00	0.00		XXX
83730		X	SIA TEST	0.00	0.00	0.00	0.00		XXX
83735		X	ASSAY BLOOD MAGNESIUM	0.00	0.00	0.00	0.00		XXX
83740		X	ASSAY BLOOD MAGNESIUM	0.00	0.00	0.00	0.00		XXX
83750		X	ASSAY BLOOD MAGNESIUM	0.00	0.00	0.00	0.00		XXX
83755		X	ASSAY URINE MAGNESIUM	0.00	0.00	0.00	0.00		XXX
83760		X	ASSAY URINE MAGNESIUM	0.00	0.00	0.00	0.00		XXX
83765		X	ASSAY URINE MAGNESIUM	0.00	0.00	0.00	0.00		XXX
83775		X	UV-ASSAY OF MD ENZYME	0.00	0.00	0.00	0.00		XXX
83785		X	ASSAY OF MANGANESE	0.00	0.00	0.00	0.00		XXX
83790		X	MANNITOL CLEARANCE TEST	0.00	0.00	0.00	0.00		XXX
83795		X	TEST URINE FOR MELANIN	0.00	0.00	0.00	0.00		XXX
83799		X	ASSAY OF MEPERIDINE	0.00	0.00	0.00	0.00		XXX
83805		X	ASSAY OF MEPROBAMATE	0.00	0.00	0.00	0.00		XXX
83825		X	ASSAY BLOOD MERCURY	0.00	0.00	0.00	0.00		XXX
83830		X	ASSAY URINE MERCURY	0.00	0.00	0.00	0.00		XXX
83835		X	ASSAY URINE METANEPHRINES	0.00	0.00	0.00	0.00		XXX
83840		X	ASSAY METHADONE	0.00	0.00	0.00	0.00		XXX
83842		X	ASSAY METHAPYRILENE	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
83845		X	ASSAY METHAQUALONE	0.00	0.00	0.00	0.00		XXX
83857		X	ASSAY METHEMALBUMIN	0.00	0.00	0.00	0.00		XXX
83858		X	ASSAY SERUM METHSUXIMIDE	0.00	0.00	0.00	0.00		XXX
83859		X	ASSAY METHYPRYLON	0.00	0.00	0.00	0.00		XXX
83860		X	TEST FOR MORPHINE	0.00	0.00	0.00	0.00		XXX
83861		X	ASSAY MORPHINE	0.00	0.00	0.00	0.00		XXX
83862		X	RIA ASSAY MORPHINE	0.00	0.00	0.00	0.00		XXX
83864		X	BLOOD MUCOPOLYSACCHARIDES	0.00	0.00	0.00	0.00		XXX
83865		X	MUCOPOLYSACCHARIDES ASSAY	0.00	0.00	0.00	0.00		XXX
83866		X	MUCOPOLYSACCHARIDES SCREEN	0.00	0.00	0.00	0.00		XXX
83872		X	ASSAY SYNOVIAL FLUID MUCIN	0.00	0.00	0.00	0.00		XXX
83873		X	RIA ASSAY, CSF PROTEIN	0.00	0.00	0.00	0.00		XXX
83874		X	MYOGLOBIN ELECTROPHORESIS	0.00	0.00	0.00	0.00		XXX
83875		X	ASSAY URINE FOR MYOGLOBIN	0.00	0.00	0.00	0.00		XXX
83880		X	ASSAY NALORPHINE	0.00	0.00	0.00	0.00		XXX
83885		X	ASSAY URINE FOR NICKEL	0.00	0.00	0.00	0.00		XXX
83887		X	ASSAY NICOTINE	0.00	0.00	0.00	0.00		XXX
83895		X	ASSAY URINE FOR NITROGEN	0.00	0.00	0.00	0.00		XXX
83900		X	ASSAY FECES FOR NITROGEN	0.00	0.00	0.00	0.00		XXX
83910		X	ASSAY BLOOD NONPROTEIN N	0.00	0.00	0.00	0.00		XXX
83912		X	GENETIC EXAMINATION	0.00	0.00	0.00	0.00		XXX
83912	26	A	GENETIC EXAMINATION	0.38	0.21	0.01	0.60	2	XXX
83913		X	NUCLEIC ACID PROBE, PCR	0.00	0.00	0.00	0.00		XXX
83915		X	ASSAY NUCLEOTIDASE	0.00	0.00	0.00	0.00		XXX
83916		X	ELECTROPHORESIS CSF GLOBULIN	0.00	0.00	0.00	0.00		XXX
83917		X	TEST FOR ORGANIC ACIDS	0.00	0.00	0.00	0.00		XXX
83918		X	ASSAY ORGANIC ACIDS	0.00	0.00	0.00	0.00		XXX
83920		X	ASSAY OCT ENZYME	0.00	0.00	0.00	0.00		XXX
83930		X	ASSAY BLOOD OSMOLALITY	0.00	0.00	0.00	0.00		XXX
83935		X	ASSAY URINE OSMOLALITY	0.00	0.00	0.00	0.00		XXX
83938		X	ASSAY OUBAIN	0.00	0.00	0.00	0.00		XXX
83945		X	ASSAY URINE OXALATE	0.00	0.00	0.00	0.00		XXX
83946		X	ASSAY OXAZEPAM	0.00	0.00	0.00	0.00		XXX
83947		X	ASSAY OXYBUTYRIC ACID	0.00	0.00	0.00	0.00		XXX
83948		X	ASSAY FOR OXYCODINONE	0.00	0.00	0.00	0.00		XXX
83949		X	RIA ASSAY OF OXYTOCINASE	0.00	0.00	0.00	0.00		XXX
83965		X	ASSAY BLOOD PARALDEHYDE	0.00	0.00	0.00	0.00		XXX
83970		X	RIA ASSAY OF PARATHORMONE	0.00	0.00	0.00	0.00		XXX
83971		X	ASSAY URINE FOR PENICILLIN	0.00	0.00	0.00	0.00		XXX
83972		X	ASSAY PENTAZOCINE	0.00	0.00	0.00	0.00		XXX
83973		X	ASSAY URINE FOR PENTOSE	0.00	0.00	0.00	0.00		XXX
83975		X	ASSAY BLOOD PEPsinogen	0.00	0.00	0.00	0.00		XXX
83985		X	TEST FOR PESTICIDE	0.00	0.00	0.00	0.00		XXX
83986		X	ASSAY BODY FLUID ACIDITY	0.00	0.00	0.00	0.00		XXX
83992		X	ASSAY FOR PHENCYCLIDINE	0.00	0.00	0.00	0.00		XXX
83995		X	ASSAY BLOOD/URINE PHENOL	0.00	0.00	0.00	0.00		XXX
84005		X	ASSAY URINE PHENOL RED	0.00	0.00	0.00	0.00		XXX
84021		X	TEST URINE PHENOTHIAZINE	0.00	0.00	0.00	0.00		XXX
84022		X	ASSAY URINE PHENOTHIAZINE	0.00	0.00	0.00	0.00		XXX
84030		X	ASSAY BLOOD PKU	0.00	0.00	0.00	0.00		XXX
84031		X	ASSAY BLOOD PKU	0.00	0.00	0.00	0.00		XXX
84033		X	ASSAY PHENYLBUTAZONE	0.00	0.00	0.00	0.00		XXX
84035		X	ASSAY BLOOD PHENYLKETONES	0.00	0.00	0.00	0.00		XXX
84037		X	TEST URINE PHENYLKETONES	0.00	0.00	0.00	0.00		XXX
84038		X	ASSAY PHENYLPROPANOLAMINE	0.00	0.00	0.00	0.00		XXX
84039		X	ASSAY BLOOD PP ACID	0.00	0.00	0.00	0.00		XXX
84040		X	ASSAY URINE PP ACID	0.00	0.00	0.00	0.00		XXX
84045		X	ASSAY PHENYTOIN	0.00	0.00	0.00	0.00		XXX
84060		X	ASSAY BLOOD ACID PHOSPHATASE	0.00	0.00	0.00	0.00		XXX
84065		X	ASSAY PROSTATE PHOSPHATASE	0.00	0.00	0.00	0.00		XXX
84066		X	ASSAY PROSTATE PHOSPHATASE	0.00	0.00	0.00	0.00		XXX
84075		X	ASSAY ALKALINE PHOSPHATASE	0.00	0.00	0.00	0.00		XXX
84078		X	ASSAY ALKALINE PHOSPHATASE	0.00	0.00	0.00	0.00		XXX
84080		X	ASSAY ALKALINE PHOSPHATASES	0.00	0.00	0.00	0.00		XXX
84081		X	AMNIOTIC FLUID ENZYME TEST	0.00	0.00	0.00	0.00		XXX
84082		X	TUBULAR REABSORPTION PO4	0.00	0.00	0.00	0.00		XXX
84083		X	ASSAY PHOSPHOGLUCOMUTASES	0.00	0.00	0.00	0.00		XXX
84085		X	ASSAY RBC PG60 ENZYME	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
84087		X	ASSAY PHOSPHOHEXOSE ENZYMES	0.00	0.00	0.00	0.00		XXX
84090		X	ASSAY BLOOD PHOSPHOLIPIDS	0.00	0.00	0.00	0.00		XXX
84100		X	ASSAY BLOOD PHOSPHORUS	0.00	0.00	0.00	0.00		XXX
84105		X	ASSAY URINE PHOSPHORUS	0.00	0.00	0.00	0.00		XXX
84106		X	TEST FOR PORPHOBILINOGEN	0.00	0.00	0.00	0.00		XXX
84110		X	ASSAY PORPHOBILINOGEN	0.00	0.00	0.00	0.00		XXX
84118		X	ASSAY URINE PORPHYRINS	0.00	0.00	0.00	0.00		XXX
84119		X	TEST URINE FOR PORPHYRINS	0.00	0.00	0.00	0.00		XXX
84120		X	ASSAY URINE PORPHYRINS	0.00	0.00	0.00	0.00		XXX
84121		X	ASSAY URINE PORPHYRINS	0.00	0.00	0.00	0.00		XXX
84126		X	ASSAY FECES PORPHYRINS	0.00	0.00	0.00	0.00		XXX
84128		X	ASSAY PLASMA PORPHYRINS	0.00	0.00	0.00	0.00		XXX
84132		X	ASSAY BLOOD POTASSIUM	0.00	0.00	0.00	0.00		XXX
84133		X	ASSAY URINE POTASSIUM	0.00	0.00	0.00	0.00		XXX
84135		X	RIA ASSAY PREGNANEDIOL	0.00	0.00	0.00	0.00		XXX
84136		X	ASSAY PREGNANEDIOL	0.00	0.00	0.00	0.00		XXX
84138		X	RIA ASSAY PREGNANETRIOL	0.00	0.00	0.00	0.00		XXX
84139		X	ASSAY PREGNANETRIOL	0.00	0.00	0.00	0.00		XXX
84141		X	ASSAY PRIMIDONE	0.00	0.00	0.00	0.00		XXX
84142		X	ASSAY PROCAINAMIDE	0.00	0.00	0.00	0.00		XXX
84144		X	ASSAY PROGESTERONE	0.00	0.00	0.00	0.00		XXX
84146		X	RIA ASSAY FOR PROLACTIN	0.00	0.00	0.00	0.00		XXX
84147		X	ASSAY PROPOXYPHENE	0.00	0.00	0.00	0.00		XXX
84149		X	ASSAY PROPRANOLOL	0.00	0.00	0.00	0.00		XXX
84150		X	RIA ASSAY OF PROSTAGLANDIN	0.00	0.00	0.00	0.00		XXX
84155		X	ASSAY SERUM PROTEIN	0.00	0.00	0.00	0.00		XXX
84160		X	ASSAY SERUM PROTEIN	0.00	0.00	0.00	0.00		XXX
84165		X	ASSAY SERUM PROTEINS	0.00	0.00	0.00	0.00		XXX
84165	26	A	ASSAY SERUM PROTEINS	0.38	0.21	0.01	0.60	2	XXX
84170		X	ASSAY SERUM A/G RATIO	0.00	0.00	0.00	0.00		XXX
84175		X	ASSAY BODY PROTEINS	0.00	0.00	0.00	0.00		XXX
84176		X	SPECIAL PROTEIN EXAMINATION	0.00	0.00	0.00	0.00		XXX
84180		X	ASSAY URINE PROTEIN	0.00	0.00	0.00	0.00		XXX
84185		X	ASSAY URINE B-J PROTEIN	0.00	0.00	0.00	0.00		XXX
84190		X	ASSAY URINE PROTEIN	0.00	0.00	0.00	0.00		XXX
84190	26	A	ASSAY URINE PROTEIN	0.38	0.21	0.01	0.60	2	XXX
84195		X	ASSAY SPINAL FLUID PROTEIN	0.00	0.00	0.00	0.00		XXX
84200		X	ASSAY SPINAL FLUID PROTEINS	0.00	0.00	0.00	0.00		XXX
84201		X	ASSAY PROTIRELIN	0.00	0.00	0.00	0.00		XXX
84202		X	ASSAY RBC PROTOPORPHYRIN	0.00	0.00	0.00	0.00		XXX
84203		X	TEST RBC PROTOPORPHYRIN	0.00	0.00	0.00	0.00		XXX
84205		X	ASSAY PROTRIPTYLENE	0.00	0.00	0.00	0.00		XXX
84206		X	RIA ASSAY OF PROINSULIN	0.00	0.00	0.00	0.00		XXX
84207		X	ASSAY VITAMIN B-6	0.00	0.00	0.00	0.00		XXX
84208		X	ASSAY URINE CRYSTALS	0.00	0.00	0.00	0.00		XXX
84210		X	ASSAY BLOOD PYRUVATE	0.00	0.00	0.00	0.00		XXX
84220		X	ASSAY RBC PYRUVIC KINASE	0.00	0.00	0.00	0.00		XXX
84228		X	ASSAY QUININE	0.00	0.00	0.00	0.00		XXX
84230		X	ASSAY QUINIDINE	0.00	0.00	0.00	0.00		XXX
84231		X	RADIOIMMUNOASSAY	0.00	0.00	0.00	0.00		XXX
84232		X	TEST RELEASING FACTOR	0.00	0.00	0.00	0.00		XXX
84233		X	ASSAY ESTROGEN	0.00	0.00	0.00	0.00		XXX
84234		X	ASSAY PROGESTERONE	0.00	0.00	0.00	0.00		XXX
84235		X	ASSAY ENDOCRINE HORMONE	0.00	0.00	0.00	0.00		XXX
84236		X	ASSAY FEMALE HORMONES	0.00	0.00	0.00	0.00		XXX
84238		X	ASSAY NON-ENDOCRINE RECEPTOR	0.00	0.00	0.00	0.00		XXX
84244		X	RIA ASSAY OF RENIN	0.00	0.00	0.00	0.00		XXX
84246		X	RENIN FUROSEMIDE TEST	0.00	0.00	0.00	0.00		XXX
84252		X	ASSAY VITAMIN B-2	0.00	0.00	0.00	0.00		XXX
84255		X	ASSAY SELENIUM	0.00	0.00	0.00	0.00		XXX
84260		X	ASSAY BLOOD SEROTONIN	0.00	0.00	0.00	0.00		XXX
84275		X	ASSAY BLOOD SIALIC ACID	0.00	0.00	0.00	0.00		XXX
84285		X	ASSAY SILICA	0.00	0.00	0.00	0.00		XXX
84295		X	ASSAY BLOOD SODIUM	0.00	0.00	0.00	0.00		XXX
84300		X	ASSAY URINE SODIUM	0.00	0.00	0.00	0.00		XXX
84310		X	ASSAY SERUM SDH ENZYME	0.00	0.00	0.00	0.00		XXX
84315		X	BODY FLUID SPECIFIC GRAVITY	0.00	0.00	0.00	0.00		XXX
84318		X	ASSAY FECES FOR STERCOBILIN	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
84324		X	ASSAY STRYCHNINE	0.00	0.00	0.00	0.00		XXX
84375		X	CHROMATOGRAM ASSAY, SUGARS	0.00	0.00	0.00	0.00		XXX
84392		X	ASSAY URINE SULFATE	0.00	0.00	0.00	0.00		XXX
84395		X	ASSAY BLOOD SULFONAMIDE	0.00	0.00	0.00	0.00		XXX
84403		X	RIA ASSAY BLOOD TESTOSTERONE	0.00	0.00	0.00	0.00		XXX
84405		X	RIA ASSAY URINE TESTOSTERONE	0.00	0.00	0.00	0.00		XXX
84406		X	ASSAY PROTEIN-TESTOSTERONE	0.00	0.00	0.00	0.00		XXX
84407		X	ASSAY TETRACAINE	0.00	0.00	0.00	0.00		XXX
84408		X	ASSAY THC	0.00	0.00	0.00	0.00		XXX
84409		X	ASSAY CORTICOSTEROID	0.00	0.00	0.00	0.00		XXX
84410		X	ASSAY THALLIUM	0.00	0.00	0.00	0.00		XXX
84420		X	ASSAY THEOPHYLLINE	0.00	0.00	0.00	0.00		XXX
84425		X	ASSAY VITAMIN B-1	0.00	0.00	0.00	0.00		XXX
84430		X	ASSAY BLOOD THIOCYANATE	0.00	0.00	0.00	0.00		XXX
84434		X	ASSAY THIODIAZINE	0.00	0.00	0.00	0.00		XXX
84435		X	ASSAY THYROXINE (T-4)	0.00	0.00	0.00	0.00		XXX
84436		X	RIA ASSAY, TRUE THYROXINE	0.00	0.00	0.00	0.00		XXX
84437		X	ASSAY NEONATAL THYROXINE	0.00	0.00	0.00	0.00		XXX
84439		X	RIA ASSAY, FREE THYROXINE	0.00	0.00	0.00	0.00		XXX
84442		X	THYROID ACTIVITY (TBG) ASSAY	0.00	0.00	0.00	0.00		XXX
84443		X	ASSAY THYROID STIM HORMONE	0.00	0.00	0.00	0.00		XXX
84444		X	RIA THYROTROPIN FACTOR	0.00	0.00	0.00	0.00		XXX
84445		X	RIA THYROTROPIN FACTOR	0.00	0.00	0.00	0.00		XXX
84446		X	ASSAY VITAMIN E	0.00	0.00	0.00	0.00		XXX
84447		X	TOXICOLOGY SCREENING	0.00	0.00	0.00	0.00		XXX
84448		X	TOXICOLOGY SEDATIVES SCREEN	0.00	0.00	0.00	0.00		XXX
84450		X	UV-ASSAY TRANSAMINASE (SGOT)	0.00	0.00	0.00	0.00		XXX
84455		X	ASSAY TRANSAMINASE (SGOT)	0.00	0.00	0.00	0.00		XXX
84460		X	UV-ASSAY TRANSAMINASE (SGPT)	0.00	0.00	0.00	0.00		XXX
84465		X	ASSAY TRANSAMINASE (SGPT)	0.00	0.00	0.00	0.00		XXX
84472		X	ASSAY TRICHLOROETHANOL	0.00	0.00	0.00	0.00		XXX
84474		X	ASSAY TRICHLOROACETIC ACID	0.00	0.00	0.00	0.00		XXX
84476		X	ASSAY TRIFLUOPERAZINE	0.00	0.00	0.00	0.00		XXX
84478		X	ASSAY BLOOD TRIGLYCERIDES	0.00	0.00	0.00	0.00		XXX
84479		X	ASSAY TRIIODOTHYRONINE (T-3)	0.00	0.00	0.00	0.00		XXX
84480		X	RIA ASSAY, TT-3	0.00	0.00	0.00	0.00		XXX
84481		X	RIA ASSAY (FT-3)	0.00	0.00	0.00	0.00		XXX
84483		X	ASSAY TRIMETHADIONE	0.00	0.00	0.00	0.00		XXX
84485		X	ASSAY DUODENAL FLUID TRYPSIN	0.00	0.00	0.00	0.00		XXX
84488		X	TEST FECES FOR TRYPSIN	0.00	0.00	0.00	0.00		XXX
84490		X	ASSAY FECES FOR TRYPSIN	0.00	0.00	0.00	0.00		XXX
84510		X	ASSAY BLOOD TYROSINE	0.00	0.00	0.00	0.00		XXX
84520		X	ASSAY BUN	0.00	0.00	0.00	0.00		XXX
84525		X	STICK-ASSAY BUN	0.00	0.00	0.00	0.00		XXX
84540		X	ASSAY URINE UREA-N	0.00	0.00	0.00	0.00		XXX
84545		X	UREA-N CLEARANCE TEST	0.00	0.00	0.00	0.00		XXX
84550		X	ASSAY BLOOD URIC ACID	0.00	0.00	0.00	0.00		XXX
84555		X	ASSAY URIC ACID	0.00	0.00	0.00	0.00		XXX
84560		X	ASSAY URINE URIC ACID	0.00	0.00	0.00	0.00		XXX
84565		X	TEST URINE UROBILIN	0.00	0.00	0.00	0.00		XXX
84570		X	ASSAY URINE UROBILIN	0.00	0.00	0.00	0.00		XXX
84575		X	ASSAY FECES UROBILIN	0.00	0.00	0.00	0.00		XXX
84577		X	ASSAY FECES UROBILINOGEN	0.00	0.00	0.00	0.00		XXX
84578		X	TEST URINE UROBILINOGEN	0.00	0.00	0.00	0.00		XXX
84580		X	ASSAY URINE UROBILINOGEN	0.00	0.00	0.00	0.00		XXX
84583		X	ASSAY URINE UROBILINOGEN	0.00	0.00	0.00	0.00		XXX
84584		X	ASSAY URINE UROPEPSIN	0.00	0.00	0.00	0.00		XXX
84585		X	ASSAY URINE VMA	0.00	0.00	0.00	0.00		XXX
84588		X	RIA ASSAY VASOPRESSIN	0.00	0.00	0.00	0.00		XXX
84589		X	ASSAY FLUID VISCOSITY	0.00	0.00	0.00	0.00		XXX
84590		X	ASSAY BLOOD VITAMIN-A	0.00	0.00	0.00	0.00		XXX
84595		X	ASSAY BLOOD VITAMIN-A	0.00	0.00	0.00	0.00		XXX
84597		X	ASSAY VITAMIN-K	0.00	0.00	0.00	0.00		XXX
84600		X	ASSAY FOR VOLATILES	0.00	0.00	0.00	0.00		XXX
84605		X	MEASURE BLOOD VOLUME	0.00	0.00	0.00	0.00		XXX
84610		X	MEASURE BLOOD VOLUME	0.00	0.00	0.00	0.00		XXX
84613		X	ASSAY WARFARIN	0.00	0.00	0.00	0.00		XXX
84615		X	ASSAY XANTHURENIC ACID	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPs*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
84620		X	XYLOSE TOLERANCE TEST	0.00	0.00	0.00	0.00		XXX
84630		X	ASSAY BLOOD ZINC	0.00	0.00	0.00	0.00		XXX
84635		X	ZINC ASSAY IN URINE	0.00	0.00	0.00	0.00		XXX
84681		X	ASSAY C-PEPTIDE	0.00	0.00	0.00	0.00		XXX
84695		X	ASSAY GENTAMICIN	0.00	0.00	0.00	0.00		XXX
84702		X	CHORIONIC GONADOTROPIN TEST	0.00	0.00	0.00	0.00		XXX
84703		X	CHORIONIC GONADOTROPIN ASSAY	0.00	0.00	0.00	0.00		XXX
84800		X	ASSAY NEONATAL TSH	0.00	0.00	0.00	0.00		XXX
84810		X	ASSAY TOBRAMYCIN	0.00	0.00	0.00	0.00		XXX
84999		X	CLINICAL CHEMISTRY TEST	0.00	0.00	0.00	0.00		XXX
85000		X	BLEEDING TIME TEST	0.00	0.00	0.00	0.00		XXX
85002		X	BLEEDING TIME TEST	0.00	0.00	0.00	0.00		XXX
85005		X	BASOPHIL BLOOD CELL COUNT	0.00	0.00	0.00	0.00		XXX
85007		X	DIFFERENTIAL WBC COUNT	0.00	0.00	0.00	0.00		XXX
85009		X	DIFFERENTIAL WBC COUNT	0.00	0.00	0.00	0.00		XXX
85012		X	EOSINOPHIL BLOOD CELL COUNT	0.00	0.00	0.00	0.00		XXX
85014		X	HEMATOCRIT	0.00	0.00	0.00	0.00		XXX
85018		X	HEMOGLOBIN, COLORIMETRIC	0.00	0.00	0.00	0.00		XXX
85021		X	AUTOMATED HEMOGRAM	0.00	0.00	0.00	0.00		XXX
85022		X	AUTOMATED HEMOGRAM	0.00	0.00	0.00	0.00		XXX
85023		X	AUTOMATED HEMOGRAM	0.00	0.00	0.00	0.00		XXX
85024		X	AUTOMATED HEMOGRAM	0.00	0.00	0.00	0.00		XXX
85025		X	AUTOMATED HEMOGRAM	0.00	0.00	0.00	0.00		XXX
85027		X	AUTOMATED HEMOGRAM	0.00	0.00	0.00	0.00		XXX
85029		X	AUTOMATED HEMOGRAM	0.00	0.00	0.00	0.00		XXX
85030		X	AUTOMATED HEMOGRAM	0.00	0.00	0.00	0.00		XXX
85031		X	MANUAL HEMOGRAM, COMPLETE CBC	0.00	0.00	0.00	0.00		XXX
85041		X	RED BLOOD CELL (RBC) COUNT	0.00	0.00	0.00	0.00		XXX
85044		X	RETICULOCYTE COUNT	0.00	0.00	0.00	0.00		XXX
85045		X	RETICULOCYTE COUNT	0.00	0.00	0.00	0.00		XXX
85048		X	WHITE BLOOD CELL (WBC) COUNT	0.00	0.00	0.00	0.00		XXX
85060	26	A	BLOOD SMEAR INTERPRETATION	0.48	0.23	0.02	0.73	1	XXX
85060		X	BLOOD SMEAR INTERPRETATION	0.00	0.00	0.00	0.00		XXX
85095		A	BONE MARROW ASPIRATION	0.85	0.71	0.05	1.61	2	XXX
85097		A	BONE MARROW INTERPRETATION	0.99	0.51	0.04	1.54	1	XXX
85100		A	BONE MARROW EXAMINATION	1.87	1.40	0.09	3.36	2	XXX
85100	TC	A	BONE MARROW EXAMINATION	0.00	0.38	0.02	0.40		XXX
85100	26	A	BONE MARROW EXAMINATION	1.87	1.02	0.07	2.96	2	XXX
85101		A	ASPIRATE, STAIN BONE MARROW	0.85	0.95	0.07	1.87	2	XXX
85101	TC	A	ASPIRATE, STAIN BONE MARROW	0.00	0.25	0.02	0.27		XXX
85101	26	A	ASPIRATE, STAIN BONE MARROW	0.85	0.70	0.05	1.60	2	XXX
85102		A	BONE MARROW BIOPSY	1.45	1.13	0.07	2.65	2	XXX
85102	TC	A	BONE MARROW BIOPSY	0.00	0.29	0.02	0.31		XXX
85102	26	A	BONE MARROW BIOPSY	1.45	0.84	0.05	2.34	2	XXX
85103		A	BONE MARROW BIOPSY & EXAM	0.66	0.74	0.04	1.44	2	XXX
85103	TC	A	BONE MARROW BIOPSY & EXAM	0.00	0.23	0.01	0.24		XXX
85103	26	A	BONE MARROW BIOPSY & EXAM	0.66	0.51	0.03	1.20	2	XXX
85105		A	BONE MARROW, INTERPRETATION	0.66	0.50	0.03	1.19	1	XXX
85109		A	BONE MARROW PREPARATION	0.00	0.63	0.04	0.67		XXX
85170		X	BLOOD CLOT RETRACTION SCREEN	0.00	0.00	0.00	0.00		XXX
85171		X	BLOOD CLOT RETRACTION ASSAY	0.00	0.00	0.00	0.00		XXX
85172		X	BLOOD CLOT RETRACTION TEST	0.00	0.00	0.00	0.00		XXX
85175		X	BLOOD CLOT LYSIS TIME	0.00	0.00	0.00	0.00		XXX
85210		X	BLOOD CLOT FACTOR II TEST	0.00	0.00	0.00	0.00		XXX
85220		X	BLOOD CLOT FACTOR V TEST	0.00	0.00	0.00	0.00		XXX
85230		X	BLOOD CLOT FACTOR VII TEST	0.00	0.00	0.00	0.00		XXX
85240		X	BLOOD CLOT FACTOR VIII TEST	0.00	0.00	0.00	0.00		XXX
85242		X	BLOOD CLOT FACTOR VIII TEST	0.00	0.00	0.00	0.00		XXX
85244		X	BLOOD CLOT FACTOR VIII TEST	0.00	0.00	0.00	0.00		XXX
85250		X	BLOOD CLOT FACTOR IX TEST	0.00	0.00	0.00	0.00		XXX
85260		X	BLOOD CLOT FACTOR X TEST	0.00	0.00	0.00	0.00		XXX
85270		X	BLOOD CLOT FACTOR XI TEST	0.00	0.00	0.00	0.00		XXX
85280		X	BLOOD CLOT FACTOR XII TEST	0.00	0.00	0.00	0.00		XXX
85290		X	BLOOD CLOT FACTOR XIII TEST	0.00	0.00	0.00	0.00		XXX
85291		X	BLOOD CLOT FACTOR XIII TEST	0.00	0.00	0.00	0.00		XXX
85292		X	BLOOD CLOT FACTOR ASSAY	0.00	0.00	0.00	0.00		XXX
85293		X	BLOOD CLOT FACTOR ASSAY	0.00	0.00	0.00	0.00		XXX
85300		X	ANTITHROMBIN III TEST	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
85301		X	ANTITHROMBIN III TEST	0.00	0.00	0.00	0.00		XXX
85302		X	BLOOD CLOT INHIBITOR ASSAY	0.00	0.00	0.00	0.00		XXX
85305		X	BLOOD CLOT INHIBITOR ASSAY	0.00	0.00	0.00	0.00		XXX
85310		X	ANTITHROMBOPLASTIN TEST	0.00	0.00	0.00	0.00		XXX
85311		X	ANTIPTROTHROMBINASE TEST	0.00	0.00	0.00	0.00		XXX
85320		X	ANTIPTROTHROMBOPLASTIN TEST	0.00	0.00	0.00	0.00		XXX
85330		X	ANTIFACTOR VIII TEST	0.00	0.00	0.00	0.00		XXX
85340		X	CROSS RECALCIFICATION TIME	0.00	0.00	0.00	0.00		XXX
85341		X	PTT INHIBITION TEST	0.00	0.00	0.00	0.00		XXX
85345		X	COAGULATION TIME	0.00	0.00	0.00	0.00		XXX
85347		X	COAGULATION TIME	0.00	0.00	0.00	0.00		XXX
85348		X	COAGULATION TIME	0.00	0.00	0.00	0.00		XXX
85360		X	EUGLOBULIN LYSIS	0.00	0.00	0.00	0.00		XXX
85362		X	FIBRIN DEGRADATION PRODUCTS	0.00	0.00	0.00	0.00		XXX
85363		X	FIBRIN DEGRADATION PRODUCTS	0.00	0.00	0.00	0.00		XXX
85364		X	FIBRIN DEGRADATION PRODUCTS	0.00	0.00	0.00	0.00		XXX
85365		X	FIBRIN DEGRADATION PRODUCTS	0.00	0.00	0.00	0.00		XXX
85367		X	FIBRIN DEGRADATION PRODUCTS	0.00	0.00	0.00	0.00		XXX
85368		X	FIBRIN DEGRADATION PRODUCTS	0.00	0.00	0.00	0.00		XXX
85369		X	FIBRIN DEGRADATION PRODUCTS	0.00	0.00	0.00	0.00		XXX
85371		X	FIBRINOGEN, SEMIQUANTITATIVE	0.00	0.00	0.00	0.00		XXX
85372		X	FIBRINOGEN, SEMIQUANTITATIVE	0.00	0.00	0.00	0.00		XXX
85376		X	FIBRINOGEN, THROMBIN	0.00	0.00	0.00	0.00		XXX
85377		X	FIBRINOGEN, THROMBIN TIME	0.00	0.00	0.00	0.00		XXX
85390		X	FIBRINOLYSINS SCREEN	0.00	0.00	0.00	0.00		XXX
85390	26	A	FIBRINOLYSINS SCREEN	0.38	0.21	0.01	0.60	2	XXX
85392		X	FIBRINOLYSINS WITH EACA	0.00	0.00	0.00	0.00		XXX
85395		X	FIBRINOLYSINS, SEMIQUANT	0.00	0.00	0.00	0.00		XXX
85398		X	FIBRINOLYSIS, QUANTITATIVE	0.00	0.00	0.00	0.00		XXX
85400		X	FIBRINOLYTIC PLASMIN	0.00	0.00	0.00	0.00		XXX
85410		X	FIBRINOLYTIC ANTIPLASMIN	0.00	0.00	0.00	0.00		XXX
85420		X	FIBRINOLYTIC PLASMINOGEN	0.00	0.00	0.00	0.00		XXX
85421		X	FIBRINOLYTIC PLASMINOGEN	0.00	0.00	0.00	0.00		XXX
85426		X	VON WILLEBRAND FACTOR ASSAY	0.00	0.00	0.00	0.00		XXX
85441		X	HEINZ BODIES; DIRECT	0.00	0.00	0.00	0.00		XXX
85445		X	HEINZ BODIES; INDUCED	0.00	0.00	0.00	0.00		XXX
85460		X	HEMOGLOBIN, FETAL	0.00	0.00	0.00	0.00		XXX
85520		X	HEPARIN ASSAY	0.00	0.00	0.00	0.00		XXX
85530		X	HEPARIN-PROTAMINE TOLERANCE	0.00	0.00	0.00	0.00		XXX
85535		X	IRON STAIN, BLOOD CELLS	0.00	0.00	0.00	0.00		XXX
85538		X	BLOOD/BONE MARROW ESTERASE	0.00	0.00	0.00	0.00		XXX
85540		X	WBC ALKALINE PHOSPHATASE	0.00	0.00	0.00	0.00		XXX
85544		X	LUPUS (LE) CELL PREP	0.00	0.00	0.00	0.00		XXX
85547		X	RBC MECHANICAL FRAGILITY	0.00	0.00	0.00	0.00		XXX
85548		X	RBC MORPHOLOGY	0.00	0.00	0.00	0.00		XXX
85549		X	SERUM MURAMIDASE	0.00	0.00	0.00	0.00		XXX
85555		X	RBC OSMOTIC FRAGILITY	0.00	0.00	0.00	0.00		XXX
85556		X	RBC OSMOTIC FRAGILITY	0.00	0.00	0.00	0.00		XXX
85557		X	RBC OSMOTIC FRAGILITY	0.00	0.00	0.00	0.00		XXX
85560		X	WBC PEROXIDASE STAIN	0.00	0.00	0.00	0.00		XXX
85575		X	BLOOD PLATELET ADHESIVENESS	0.00	0.00	0.00	0.00		XXX
85576		X	BLOOD PLATELET AGGREGATION	0.00	0.00	0.00	0.00		XXX
85576	26	A	BLOOD PLATELET AGGREGATION	0.38	0.21	0.01	0.60	2	XXX
85577		X	BLOOD PLATELET RETENTION	0.00	0.00	0.00	0.00		XXX
85580		X	BLOOD PLATELET COUNT	0.00	0.00	0.00	0.00		XXX
85585		X	BLOOD PLATELET ESTIMATION	0.00	0.00	0.00	0.00		XXX
85590		X	PLATELET PHASE MICROSCOPY	0.00	0.00	0.00	0.00		XXX
85595		X	ELECTRONIC PLATELET COUNT	0.00	0.00	0.00	0.00		XXX
85610		X	PROTHROMBIN TIME	0.00	0.00	0.00	0.00		XXX
85612		X	VIPER VENOM PROTHROMBIN TIME	0.00	0.00	0.00	0.00		XXX
85615		X	PROTHROMBIN UTILIZATION TEST	0.00	0.00	0.00	0.00		XXX
85618		X	PROTHROMBIN-PROCONVERTIN	0.00	0.00	0.00	0.00		XXX
85630		X	RED BLOOD CELL SIZE	0.00	0.00	0.00	0.00		XXX
85632		X	RBC PEROXIDE HEMOLYSIS	0.00	0.00	0.00	0.00		XXX
85635		X	REPTILASE TEST	0.00	0.00	0.00	0.00		XXX
85650		X	RBC SEDIMENTATION RATE	0.00	0.00	0.00	0.00		XXX
85651		X	RBC SEDIMENTATION RATE	0.00	0.00	0.00	0.00		XXX
85660		X	RBC SICKLE CELL TEST	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
85665		X	STREPTOKINASE TITER	0.00	0.00	0.00	0.00		XXX
85667		X	T-CELL DEPLETION	0.00	0.00	0.00	0.00		XXX
85670		X	THROMBIN TIME; PLASMA	0.00	0.00	0.00	0.00		XXX
85675		X	THROMBIN TIME; TITER	0.00	0.00	0.00	0.00		XXX
85700		X	THROMBOPLASTIN GENERATION	0.00	0.00	0.00	0.00		XXX
85710		X	THROMBOPLASTIN GENERATION	0.00	0.00	0.00	0.00		XXX
85711		X	THROMBOPLASTIN GENERATION	0.00	0.00	0.00	0.00		XXX
85720		X	THROMBOPLASTIN GENERATION	0.00	0.00	0.00	0.00		XXX
85730		X	THROMBOPLASTIN TIME, PARTIAL	0.00	0.00	0.00	0.00		XXX
85732		X	THROMBOPLASTIN TIME, PARTIAL	0.00	0.00	0.00	0.00		XXX
85810		X	BLOOD VISCOSITY EXAMINATION	0.00	0.00	0.00	0.00		XXX
85820		X	SERUM VISCOSITY EXAMINATION	0.00	0.00	0.00	0.00		XXX
85999		X	HEMATOLOGY PROCEDURE	0.00	0.00	0.00	0.00		XXX
86000		X	AGGLUTININS; FEBRILE	0.00	0.00	0.00	0.00		XXX
86002		X	AGGLUTININS; PANEL	0.00	0.00	0.00	0.00		XXX
86004		X	AGGLUTININS; WARM	0.00	0.00	0.00	0.00		XXX
86006		X	ANTIBODY, QUALITATIVE, FIRST	0.00	0.00	0.00	0.00		XXX
86007		X	ANTIBODY, QUAL., EACH ADDED	0.00	0.00	0.00	0.00		XXX
86008		X	ANTIBODY, QUANT., FIRST	0.00	0.00	0.00	0.00		XXX
86009		X	ANTIBODY, QUANT., EACH ADDED	0.00	0.00	0.00	0.00		XXX
86011		X	LEUKOCYTE ANTIBODY DETECTION	0.00	0.00	0.00	0.00		XXX
86012		X	COLD AUTOANTIBODY ABSORPTION	0.00	0.00	0.00	0.00		XXX
86013		X	COLD AUTOANTIBODY ABSORPTION	0.00	0.00	0.00	0.00		XXX
86014		X	PLATELET AGGLUTININS	0.00	0.00	0.00	0.00		XXX
86016		X	RBC ANTIBODY SCREEN	0.00	0.00	0.00	0.00		XXX
86019		X	RBC ANTIBODY ELUTION	0.00	0.00	0.00	0.00		XXX
86021		X	WBC ANTIBODY IDENTIFICATION	0.00	0.00	0.00	0.00		XXX
86022		X	PLATELET ANTIBODIES	0.00	0.00	0.00	0.00		XXX
86023		X	IMMUNOGLOBULIN ASSAY	0.00	0.00	0.00	0.00		XXX
86024		X	RBC ANTIBODY IDENTIFICATION	0.00	0.00	0.00	0.00		XXX
86031		X	ANTI HUMAN GLOBULIN TEST	0.00	0.00	0.00	0.00		XXX
86032		X	ANTI HUMAN GLOBULIN TEST	0.00	0.00	0.00	0.00		XXX
86033		X	ANTI HUMAN GLOBULIN TEST	0.00	0.00	0.00	0.00		XXX
86034		X	ANTI HUMAN GLOBULIN TEST	0.00	0.00	0.00	0.00		XXX
86038		X	ANTINUCLEAR ANTIBODIES, RIA	0.00	0.00	0.00	0.00		XXX
86060		X	ANTISTREPTOLYSIN O TITER	0.00	0.00	0.00	0.00		XXX
86063		X	ANTISTREPTOLYSIN O SCREEN	0.00	0.00	0.00	0.00		XXX
86064		X	ANTITRYPSIN, ALPHA 1, RIA	0.00	0.00	0.00	0.00		XXX
86066		X	ANTITRYPSIN PI TYPING	0.00	0.00	0.00	0.00		XXX
86067		X	ANTITRYPSIN, ALPHA-1, TEST	0.00	0.00	0.00	0.00		XXX
86068		X	BLOOD COMPATIBILITY TEST	0.00	0.00	0.00	0.00		XXX
86070		X	BLOOD COMPATIBILITY TEST	0.00	0.00	0.00	0.00		XXX
86077	A		PHYSICIAN BLOOD BANK SERVICE	0.38	0.31	0.02	0.71	2	XXX
86078	A		PHYSICIAN BLOOD BANK SERVICE	0.99	0.35	0.02	1.36	1	XXX
86079	A		PHYSICIAN BLOOD BANK SERVICE	0.38	0.34	0.02	0.74	2	XXX
86080		X	BLOOD TYPING, ABO ONLY	0.00	0.00	0.00	0.00		XXX
86082		X	BLOOD TYPING, ABO & RHO(D)	0.00	0.00	0.00	0.00		XXX
86083		X	BLOOD TYPING; ANTIBODY SCREEN	0.00	0.00	0.00	0.00		XXX
86084		X	BLOOD TYPING; ANTIGEN SCREEN	0.00	0.00	0.00	0.00		XXX
86085		X	BLOOD TYPING; ANTIGEN SCREEN	0.00	0.00	0.00	0.00		XXX
86095		X	BLOOD TYPING, OTHER ANTIGENS	0.00	0.00	0.00	0.00		XXX
86100		X	BLOOD TYPING, RHO(D) ONLY	0.00	0.00	0.00	0.00		XXX
86105		X	BLOOD TYPING, RH GENOTYPING	0.00	0.00	0.00	0.00		XXX
86115		X	BLOOD TYPING, RHOGAM TYPE	0.00	0.00	0.00	0.00		XXX
86128		X	COLLECT, STORAGE PT OWN BLOOD	0.00	0.00	0.00	0.00		XXX
86130		X	COLLECT, PROCESS PT OWN BLOOD	0.00	0.00	0.00	0.00		XXX
86140		X	C-REACTIVE PROTEIN	0.00	0.00	0.00	0.00		XXX
86149		X	CARCINOEMBRYONIC ANTIGEN, GEL	0.00	0.00	0.00	0.00		XXX
86151		X	CEA ASSAY, RIA OR EIA	0.00	0.00	0.00	0.00		XXX
86155		X	CHEMOTAXIS ASSAY	0.00	0.00	0.00	0.00		XXX
86158		X	COMPLEMENT; C'1 ESTERASE	0.00	0.00	0.00	0.00		XXX
86159		X	COMPLEMENT; C'2 ESTERASE	0.00	0.00	0.00	0.00		XXX
86162		X	COMPLEMENT; TOTAL (CH 50)	0.00	0.00	0.00	0.00		XXX
86163		X	COMPLEMENT; C'3 ESTERASE	0.00	0.00	0.00	0.00		XXX
86164		X	COMPLEMENT; C'4 ESTERASE	0.00	0.00	0.00	0.00		XXX
86171		X	COMPLEMENT FIXATION, EACH	0.00	0.00	0.00	0.00		XXX
86185		X	COUNTERELECTROPHORESIS, EACH	0.00	0.00	0.00	0.00		XXX
86215		X	DEOXYRIBONUCLEASE, ANTIBODY	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
86225		X	DNA ANTIBODY	0.00	0.00	0.00	0.00		XXX
86235		X	NUCLEAR ANTIGEN ANTIBODY	0.00	0.00	0.00	0.00		XXX
86243		X	FC RECEPTOR ASSAY	0.00	0.00	0.00	0.00		XXX
86244		X	ASSAY ALPHA-1 FETOPROTEIN	0.00	0.00	0.00	0.00		XXX
86255		X	FLUORESCENT ANTIBODY; SCREEN	0.00	0.00	0.00	0.00		XXX
86255	26	A	FLUORESCENT ANTIBODY; SCREEN	0.38	0.21	0.01	0.60	2	XXX
86256		X	FLUORESCENT ANTIBODY; TITER	0.00	0.00	0.00	0.00		XXX
86256	26	A	FLUORESCENT ANTIBODY; TITER	0.38	0.21	0.01	0.60	2	XXX
86265		X	BLOOD UNIT SERVICE	0.00	0.00	0.00	0.00		XXX
86266		X	BLOOD UNIT SERVICE	0.00	0.00	0.00	0.00		XXX
86267		X	BLOOD UNIT SERVICE	0.00	0.00	0.00	0.00		XXX
86277		X	GROWTH HORMONE ANTIBODY, RIA	0.00	0.00	0.00	0.00		XXX
86280		X	HEMAGGLUTINATION INHIBITION	0.00	0.00	0.00	0.00		XXX
86281		X	ACID HEMOLYSINS, HAM TEST	0.00	0.00	0.00	0.00		XXX
86282		X	HEMOLYSINS AND AGGLUTININS	0.00	0.00	0.00	0.00		XXX
86283		X	HEMOLYSINS AND AGGLUTININS	0.00	0.00	0.00	0.00		XXX
86287		X	HEPATITIS HAA, RIA, OR EIA	0.00	0.00	0.00	0.00		XXX
86288		X	HEPATITIS B CORE ANTIGEN RIA	0.00	0.00	0.00	0.00		XXX
86289		X	HEPATITIS BC ANTIBODY TEST	0.00	0.00	0.00	0.00		XXX
86290		X	HEPATITIS BC ANTIBODY TEST	0.00	0.00	0.00	0.00		XXX
86291		X	HEPATITIS BS ANTIBODY TEST	0.00	0.00	0.00	0.00		XXX
86293		X	HEPATITIS BE ANTIBODY TEST	0.00	0.00	0.00	0.00		XXX
86295		X	HEPATITIS BE ANTIBODY TEST	0.00	0.00	0.00	0.00		XXX
86296		X	HEPATITIS A ANTIBODY TEST	0.00	0.00	0.00	0.00		XXX
86298		X	HEPATITIS A ANTIBODY TEST	0.00	0.00	0.00	0.00		XXX
86299		X	HEPATITIS A ANTIBODY TEST	0.00	0.00	0.00	0.00		XXX
86300		X	HETEROPHILE ANTIBODY SCREEN	0.00	0.00	0.00	0.00		XXX
86305		X	HETEROPHILE ANTIBODY TITER	0.00	0.00	0.00	0.00		XXX
86310		X	HETEROPHILE ANTIBODIES	0.00	0.00	0.00	0.00		XXX
86311		X	HIV ANTIGEN TEST	0.00	0.00	0.00	0.00		XXX
86312		X	HIV ANTIBODY DETECTION	0.00	0.00	0.00	0.00		XXX
86314		X	HIV CONFIRMATORY TEST	0.00	0.00	0.00	0.00		XXX
86316		X	IMMUNOASSAY, TUMOR ANTIGEN	0.00	0.00	0.00	0.00		XXX
86317		X	IMMUNOASSAY, INFECTIOUS AGENT	0.00	0.00	0.00	0.00		XXX
86318		X	ASSAY, CHEMICAL AGENT	0.00	0.00	0.00	0.00		XXX
86319		X	IMMUNOASSAY FOR DRUGS	0.00	0.00	0.00	0.00		XXX
86320		X	SERUM IMMUNOELECTROPHORESIS	0.00	0.00	0.00	0.00		XXX
86320	26	A	SERUM IMMUNOELECTROPHORESIS	0.38	0.21	0.01	0.60	2	XXX
86325		X	OTHER IMMUNOELECTROPHORESIS	0.00	0.00	0.00	0.00		XXX
86325	26	A	OTHER IMMUNOELECTROPHORESIS	0.38	0.21	0.01	0.60	2	XXX
86327		X	IMMUNOELECTROPHORESIS ASSAY	0.00	0.00	0.00	0.00		XXX
86327	26	A	IMMUNOELECTROPHORESIS ASSAY	0.38	0.21	0.01	0.60	2	XXX
86329		X	IMMUNODIFFUSION, EACH	0.00	0.00	0.00	0.00		XXX
86331		X	IMMUNODIFFUSION OUCHTERLONY	0.00	0.00	0.00	0.00		XXX
86332		X	ASSAY, C1Q PRECIPITIN	0.00	0.00	0.00	0.00		XXX
86333		X	ASSAY, RAJI CELL	0.00	0.00	0.00	0.00		XXX
86334		X	IMMUNOFIXATION PROCEDURE	0.00	0.00	0.00	0.00		XXX
86334	26	A	IMMUNOFIXATION PROCEDURE	0.38	0.21	0.01	0.60	2	XXX
86335		X	IMMUNOGLOBULIN TYPING, EACH	0.00	0.00	0.00	0.00		XXX
86337		X	INSULIN ANTIBODIES, RIA	0.00	0.00	0.00	0.00		XXX
86338		X	INSULIN FACTOR ANTIBODY, RIA	0.00	0.00	0.00	0.00		XXX
86340		X	INTRINSIC FACTOR ANTIBODY	0.00	0.00	0.00	0.00		XXX
86342		X	IRRADIATION OF BLOOD PRODUCT	0.00	0.00	0.00	0.00		XXX
86343		X	LEUKOCYTE HISTAMINE RELEASE	0.00	0.00	0.00	0.00		XXX
86344		X	LEUKOCYTE PHAGOCYTOSIS	0.00	0.00	0.00	0.00		XXX
86349		X	LEUKOCYTE TRANSFUSION	0.00	0.00	0.00	0.00		XXX
86353		X	LYMPHOCYTE TRANSFORMATION	0.00	0.00	0.00	0.00		XXX
86357		X	LYMPHOCYTES, T&B DISTINCTION	0.00	0.00	0.00	0.00		XXX
86358		X	LYMPHOCYTES, B-CELL STUDY	0.00	0.00	0.00	0.00		XXX
86376		X	MICROSOMAL ANTIBODY, RIA	0.00	0.00	0.00	0.00		XXX
86377		X	MICROSOMAL ANTIBODY, THYROID	0.00	0.00	0.00	0.00		XXX
86378		X	MIGRATION INHIBITORY FACTOR	0.00	0.00	0.00	0.00		XXX
86382		X	NEUTRALIZATION TEST, VIRAL	0.00	0.00	0.00	0.00		XXX
86384		X	NITROBLUE TETRAZOLIUM DYE	0.00	0.00	0.00	0.00		XXX
86385		X	PATERNITY TESTING, ABO+RH	0.00	0.00	0.00	0.00		XXX
86386		X	PATERNITY TESTING, ABO+RH	0.00	0.00	0.00	0.00		XXX
86403		X	RAPID TEST, INFECTIOUS AGENT	0.00	0.00	0.00	0.00		XXX
86404		X	POOLING OF BLOOD PRODUCTS	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPs*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
86405		X	PRECIPITIN TEST FOR BLOOD	0.00	0.00	0.00	0.00		XXX
86410		X	PRETREATMENT RBCS; DRUGS	0.00	0.00	0.00	0.00		XXX
86411		X	PRETREATMENT RBCS; ENZYMES	0.00	0.00	0.00	0.00		XXX
86412		X	PRETREATMENT RBCS; SEPARATION	0.00	0.00	0.00	0.00		XXX
86417		X	PRETREATMENT SERUM; DRUGS	0.00	0.00	0.00	0.00		XXX
86418		X	PRETREATMENT SERUM; DILUTION	0.00	0.00	0.00	0.00		XXX
86419		X	PRETREATMENT RBCS; INCUBATION	0.00	0.00	0.00	0.00		XXX
86420		X	PRETREATMENT RBCS; ABSORPTION	0.00	0.00	0.00	0.00		XXX
86421		X	RADIOALLERGOSORBENT TESTS	0.00	0.00	0.00	0.00		XXX
86422		X	RADIOALLERGOSORBENT TESTS	0.00	0.00	0.00	0.00		XXX
86423		X	RADIOIMMUNOSORBENT TEST IGE	0.00	0.00	0.00	0.00		XXX
86430		X	RHEUMATOID FACTOR TEST	0.00	0.00	0.00	0.00		XXX
86455	A		REDUCED ALLERGY SKIN TEST	0.00	0.42	0.03	0.45		XXX
86490	A		COCCIDIOIDOMYCOSIS SKIN TEST	0.00	0.29	0.02	0.31		XXX
86510	A		HISTOPLASMOSIS SKIN TEST	0.00	0.31	0.02	0.33		XXX
86540	A		MUMPS SKIN TEST	0.00	0.27	0.02	0.29		XXX
86580	A		TB INTRADERMAL TEST	0.00	0.25	0.02	0.27		XXX
86585	A		TB TINE TEST	0.00	0.20	0.01	0.21		XXX
86587	X		SPLITTING OF BLOOD	0.00	0.00	0.00	0.00		XXX
86590	X		STREPTOKINASE, ANTIBODY	0.00	0.00	0.00	0.00		XXX
86592	X		BLOOD SEROLOGY, QUALITATIVE	0.00	0.00	0.00	0.00		XXX
86593	X		BLOOD SEROLOGY, QUANTITATIVE	0.00	0.00	0.00	0.00		XXX
86594	X		THYROID AUTOANTIBODIES	0.00	0.00	0.00	0.00		XXX
86595	X		TISSUE CULTURE	0.00	0.00	0.00	0.00		XXX
86600	X		TOXOPLASMOSIS, DYE TEST	0.00	0.00	0.00	0.00		XXX
86630	X		TRANSFER FACTOR TEST (TFT)	0.00	0.00	0.00	0.00		XXX
86650	X		TREPONEMA ANTIBODIES, FTA-ABS	0.00	0.00	0.00	0.00		XXX
86662	X		TREPONEMA PALLIDUM TEST	0.00	0.00	0.00	0.00		XXX
86681	X		ADRENAL CORTEX ANTIBODY, RIA	0.00	0.00	0.00	0.00		XXX
86685	X		ANTI-ACLR ANTIBODY	0.00	0.00	0.00	0.00		XXX
86687	X		HTLV I ANTIBODY DETECTION	0.00	0.00	0.00	0.00		XXX
86689	X		HTLV I CONFIRMATORY TEST	0.00	0.00	0.00	0.00		XXX
86800	X		THYROGLOBULIN ANTIBODY, RIA	0.00	0.00	0.00	0.00		XXX
86805	X		LYMPHOCYTOTOXICITY ASSAY	0.00	0.00	0.00	0.00		XXX
86806	X		LYMPHOCYTOTOXICITY ASSAY	0.00	0.00	0.00	0.00		XXX
86807	X		CYTOTOXIC ANTIBODY SCREENING	0.00	0.00	0.00	0.00		XXX
86808	X		CYTOTOXIC ANTIBODY SCREENING	0.00	0.00	0.00	0.00		XXX
86812	X		HLA TYPING, A, B, OR C	0.00	0.00	0.00	0.00		XXX
86813	X		HLA TYPING, A, B, AND/OR C	0.00	0.00	0.00	0.00		XXX
86816	X		HLA TYPING, DR	0.00	0.00	0.00	0.00		XXX
86817	X		HLA TYPING, DR	0.00	0.00	0.00	0.00		XXX
86821	X		LYMPHOCYTE CULTURE, MIXED	0.00	0.00	0.00	0.00		XXX
86822	X		LYMPHOCYTE CULTURE, PRIMED	0.00	0.00	0.00	0.00		XXX
86999	X		IMMUNOLOGY PROCEDURE	0.00	0.00	0.00	0.00		XXX
87001	X		SMALL ANIMAL INOCULATION	0.00	0.00	0.00	0.00		XXX
87003	X		SMALL ANIMAL INOCULATION	0.00	0.00	0.00	0.00		XXX
87015	X		SPECIMEN CONCENTRATION	0.00	0.00	0.00	0.00		XXX
87040	X		BLOOD CULTURE FOR BACTERIA	0.00	0.00	0.00	0.00		XXX
87045	X		STOOL CULTURE FOR BACTERIA	0.00	0.00	0.00	0.00		XXX
87060	X		NOSE/THROAT CULTURE, BACTERIA	0.00	0.00	0.00	0.00		XXX
87070	X		CULTURE SPECIMEN, BACTERIA	0.00	0.00	0.00	0.00		XXX
87072	X		CULTURE OF SPECIMEN BY KIT	0.00	0.00	0.00	0.00		XXX
87075	X		CULTURE SPECIMEN, BACTERIA	0.00	0.00	0.00	0.00		XXX
87076	X		BACTERIA IDENTIFICATION	0.00	0.00	0.00	0.00		XXX
87081	X		BACTERIA CULTURE SCREEN	0.00	0.00	0.00	0.00		XXX
87082	X		CULTURE OF SPECIMEN BY KIT	0.00	0.00	0.00	0.00		XXX
87083	X		CULTURE OF SPECIMEN BY KIT	0.00	0.00	0.00	0.00		XXX
87084	X		CULTURE OF SPECIMEN BY KIT	0.00	0.00	0.00	0.00		XXX
87085	X		CULTURE OF SPECIMEN BY KIT	0.00	0.00	0.00	0.00		XXX
87086	X		URINE CULTURE, COLONY COUNT	0.00	0.00	0.00	0.00		XXX
87087	X		URINE BACTERIA CULTURE	0.00	0.00	0.00	0.00		XXX
87088	X		URINE BACTERIA CULTURE	0.00	0.00	0.00	0.00		XXX
87101	X		SKIN FUNGUS CULTURE	0.00	0.00	0.00	0.00		XXX
87102	X		FUNGUS ISOLATION CULTURE	0.00	0.00	0.00	0.00		XXX
87103	X		BLOOD FUNGUS CULTURE	0.00	0.00	0.00	0.00		XXX
87106	X		FUNGUS IDENTIFICATION	0.00	0.00	0.00	0.00		XXX
87109	X		MYCOPLASMA CULTURE	0.00	0.00	0.00	0.00		XXX
87110	X		CULTURE, CHLAMYDIA	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
87116		X	MYCOBACTERIA CULTURE	0.00	0.00	0.00	0.00		XXX
87117		X	MYCOBACTERIA CULTURE	0.00	0.00	0.00	0.00		XXX
87118		X	MYCOBACTERIA IDENTIFICATION	0.00	0.00	0.00	0.00		XXX
87140		X	CULTURE TYPING, FLUORESCENT	0.00	0.00	0.00	0.00		XXX
87143		X	CULTURE TYPING, GLC METHOD	0.00	0.00	0.00	0.00		XXX
87145		X	CULTURE TYPING, PHAGE METHOD	0.00	0.00	0.00	0.00		XXX
87147		X	CULTURE TYPING, SEROLOGIC	0.00	0.00	0.00	0.00		XXX
87151		X	CULTURE TYPING, SEROLOGIC	0.00	0.00	0.00	0.00		XXX
87155		X	CULTURE TYPING, PRECIPITIN	0.00	0.00	0.00	0.00		XXX
87158		X	CULTURE TYPING, ADDED METHOD	0.00	0.00	0.00	0.00		XXX
87163		X	SPECIAL MICROBIOLOGY CULTURE	0.00	0.00	0.00	0.00		XXX
87164		X	DARK FIELD EXAMINATION	0.00	0.00	0.00	0.00		XXX
87164	26	A	DARK FIELD EXAMINATION	0.38	0.21	0.01	0.60	2	XXX
87166		X	DARK FIELD EXAMINATION	0.00	0.00	0.00	0.00		XXX
87174		X	ENDOTOXIN, BACTERIAL	0.00	0.00	0.00	0.00		XXX
87175		X	ASSAY, ENDOTOXIN, BACTERIAL	0.00	0.00	0.00	0.00		XXX
87176		X	ENDOTOXIN, BACTERIAL	0.00	0.00	0.00	0.00		XXX
87177		X	OVA AND PARASITES SMEARS	0.00	0.00	0.00	0.00		XXX
87178		X	MICROBE IDENTIFICATION	0.00	0.00	0.00	0.00		XXX
87179		X	MICROBE IDENTIFICATION	0.00	0.00	0.00	0.00		XXX
87181		X	ANTIBIOTIC SENSITIVITY, EACH	0.00	0.00	0.00	0.00		XXX
87184		X	ANTIBIOTIC SENSITIVITY, EACH	0.00	0.00	0.00	0.00		XXX
87186		X	ANTIBIOTIC SENSITIVITY, MIC	0.00	0.00	0.00	0.00		XXX
87187		X	ANTIBIOTIC SENSITIVITY, MBC	0.00	0.00	0.00	0.00		XXX
87188		X	ANTIBIOTIC SENSITIVITY, EACH	0.00	0.00	0.00	0.00		XXX
87190		X	TB ANTIBIOTIC SENSITIVITY	0.00	0.00	0.00	0.00		XXX
87192		X	ANTIBIOTIC SENSITIVITY, EACH	0.00	0.00	0.00	0.00		XXX
87197		X	BACTERICIDAL LEVEL, SERUM	0.00	0.00	0.00	0.00		XXX
87205		X	SMEAR, STAIN & INTERPRET	0.00	0.00	0.00	0.00		XXX
87206		X	SMEAR, STAIN & INTERPRET	0.00	0.00	0.00	0.00		XXX
87207		X	SMEAR, STAIN & INTERPRET	0.00	0.00	0.00	0.00		XXX
87207	26	A	SMEAR, STAIN & INTERPRET	0.38	0.21	0.01	0.60	2	XXX
87208		X	SMEAR, STAIN & INTERPRET	0.00	0.00	0.00	0.00		XXX
87210		X	SMEAR, STAIN & INTERPRET	0.00	0.00	0.00	0.00		XXX
87211		X	SMEAR, STAIN & INTERPRET	0.00	0.00	0.00	0.00		XXX
87220		X	TISSUE EXAM FOR FUNGI	0.00	0.00	0.00	0.00		XXX
87230		X	ASSAY, TOXIN OR ANTITOXIN	0.00	0.00	0.00	0.00		XXX
87250		X	VIRUS INOCULATION FOR TEST	0.00	0.00	0.00	0.00		XXX
87252		X	VIRUS INOCULATION FOR TEST	0.00	0.00	0.00	0.00		XXX
87253		X	VIRUS INOCULATION FOR TEST	0.00	0.00	0.00	0.00		XXX
87999		X	MICROBIOLOGY PROCEDURE	0.00	0.00	0.00	0.00		XXX
88000		N	AUTOPSY (NECROPSY), GROSS	0.00	0.00	0.00	0.00		XXX
88005		N	AUTOPSY (NECROPSY), GROSS	0.00	0.00	0.00	0.00		XXX
88007		N	AUTOPSY (NECROPSY), GROSS	0.00	0.00	0.00	0.00		XXX
88012		N	AUTOPSY (NECROPSY), GROSS	0.00	0.00	0.00	0.00		XXX
88014		N	AUTOPSY (NECROPSY), GROSS	0.00	0.00	0.00	0.00		XXX
88016		N	AUTOPSY (NECROPSY), GROSS	0.00	0.00	0.00	0.00		XXX
88020		N	AUTOPSY (NECROPSY), COMPLETE	0.00	0.00	0.00	0.00		XXX
88025		N	AUTOPSY (NECROPSY), COMPLETE	0.00	0.00	0.00	0.00		XXX
88027		N	AUTOPSY (NECROPSY), COMPLETE	0.00	0.00	0.00	0.00		XXX
88028		N	AUTOPSY (NECROPSY), COMPLETE	0.00	0.00	0.00	0.00		XXX
88029		N	AUTOPSY (NECROPSY), COMPLETE	0.00	0.00	0.00	0.00		XXX
88036		N	LIMITED AUTOPSY	0.00	0.00	0.00	0.00		XXX
88037		N	LIMITED AUTOPSY	0.00	0.00	0.00	0.00		XXX
88040		N	FORENSIC AUTOPSY (NECROPSY)	0.00	0.00	0.00	0.00		XXX
88045		N	CORONER'S AUTOPSY (NECROPSY)	0.00	0.00	0.00	0.00		XXX
88099		N	NECROPSY (AUTOPSY) PROCEDURE	0.00	0.00	0.00	0.00		XXX
88104		A	MICROSCOPIC EXAM OF CELLS	0.53	0.35	0.03	0.91	2	XXX
88104	TC	A	MICROSCOPIC EXAM OF CELLS	0.00	0.11	0.01	0.12		XXX
88104	26	A	MICROSCOPIC EXAM OF CELLS	0.53	0.24	0.02	0.79	2	XXX
88106		A	MICROSCOPIC EXAM OF CELLS	0.53	0.30	0.02	0.85	2	XXX
88106	TC	A	MICROSCOPIC EXAM OF CELLS	0.00	0.09	0.01	0.10		XXX
88106	26	A	MICROSCOPIC EXAM OF CELLS	0.53	0.21	0.01	0.75	2	XXX
88107		A	MICROSCOPIC EXAM OF CELLS	0.80	0.37	0.03	1.20	2	XXX
88107	TC	A	MICROSCOPIC EXAM OF CELLS	0.00	0.12	0.01	0.13		XXX
88107	26	A	MICROSCOPIC EXAM OF CELLS	0.80	0.25	0.02	1.07	2	XXX
88108		A	MICROSCOPIC EXAM OF CELLS	0.53	0.37	0.03	0.93	2	XXX
88108	TC	A	MICROSCOPIC EXAM OF CELLS	0.00	0.12	0.01	0.13		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
88108	26	A	MICROSCOPIC EXAM OF CELLS	0.53	0.25	0.02	0.80	2	XXX
88125		A	FORENSIC CYTOPATHOLOGY	0.27	0.09	0.00	0.36	2	XXX
88125	TC	A	FORENSIC CYTOPATHOLOGY	0.00	0.02	0.00	0.02		XXX
88125	26	A	FORENSIC CYTOPATHOLOGY	0.27	0.07	0.00	0.34	2	XXX
88130		X	SEX CHROMATIN IDENTIFICATION	0.00	0.00	0.00	0.00		XXX
88140		X	SEX CHROMATIN IDENTIFICATION	0.00	0.00	0.00	0.00		XXX
88150		X	CYTOPATHOLOGY, PAP SMEAR	0.00	0.00	0.00	0.00		XXX
88151	26	A	CYTOPATHOLOGY INTERPRETATION	0.44	0.33	0.04	0.81	1	XXX
88151		X	CYTOPATHOLOGY INTERPRETATION	0.00	0.00	0.00	0.00		XXX
88155		X	CYTOPATHOLOGY, PAP SMEAR	0.00	0.00	0.00	0.00		XXX
88160		A	CYTOPATHOLOGY	0.53	0.25	0.02	0.80	2	XXX
88160	TC	A	CYTOPATHOLOGY	0.00	0.08	0.01	0.09		XXX
88160	26	A	CYTOPATHOLOGY	0.53	0.17	0.01	0.71	2	XXX
88161		A	CYTOPATHOLOGY	0.53	0.31	0.02	0.86	2	XXX
88161	TC	A	CYTOPATHOLOGY	0.00	0.10	0.01	0.11		XXX
88161	26	A	CYTOPATHOLOGY	0.53	0.21	0.01	0.75	2	XXX
88162		A	CYTOPATHOLOGY, EXTENSIVE	0.80	0.63	0.04	1.47	2	XXX
88162	TC	A	CYTOPATHOLOGY, EXTENSIVE	0.00	0.20	0.01	0.21		XXX
88162	26	A	CYTOPATHOLOGY, EXTENSIVE	0.80	0.43	0.03	1.26	2	XXX
88170		A	FINE NEEDLE ASPIRATION	0.54	0.81	0.07	1.42	2	XXX
88170	TC	A	FINE NEEDLE ASPIRATION	0.00	0.25	0.02	0.27		XXX
88170	26	A	FINE NEEDLE ASPIRATION	0.54	0.56	0.05	1.15	2	XXX
88171		A	FINE NEEDLE ASPIRATION	1.10	1.09	0.07	2.26	2	XXX
88171	TC	A	FINE NEEDLE ASPIRATION	0.00	0.34	0.02	0.36		XXX
88171	26	A	FINE NEEDLE ASPIRATION	1.10	0.75	0.05	1.90	2	XXX
88172		A	EVALUATION OF SMEAR	0.64	0.55	0.04	1.23	2	XXX
88172	TC	A	EVALUATION OF SMEAR	0.00	0.18	0.01	0.19		XXX
88172	26	A	EVALUATION OF SMEAR	0.64	0.37	0.03	1.04	2	XXX
88173		A	INTERPRETATION OF SMEAR	1.06	0.70	0.04	1.80	2	XXX
88173	TC	A	INTERPRETATION OF SMEAR	0.00	0.22	0.01	0.23		XXX
88173	26	A	INTERPRETATION OF SMEAR	1.06	0.48	0.03	1.57	2	XXX
88180		A	CELL MARKER STUDY	0.19	0.26	0.02	0.47	2	XXX
88180	TC	A	CELL MARKER STUDY	0.00	0.08	0.01	0.09		XXX
88180	26	A	CELL MARKER STUDY	0.19	0.18	0.01	0.38	2	XXX
88182		A	CELL MARKER STUDY	0.81	0.70	0.05	1.56	2	XXX
88182	TC	A	CELL MARKER STUDY	0.00	0.23	0.02	0.25		XXX
88182	26	A	CELL MARKER STUDY	0.81	0.47	0.03	1.31	2	XXX
88199		C	CYTOPATHOLOGY PROCEDURE	0.00	0.00	0.00	0.00		XXX
88230		X	TISSUE CULTURE, LYMPHOCYTE	0.00	0.00	0.00	0.00		XXX
88233		X	TISSUE CULTURE, SKIN/BIOPSY	0.00	0.00	0.00	0.00		XXX
88235		X	TISSUE CULTURE, PLACENTA	0.00	0.00	0.00	0.00		XXX
88237		X	TISSUE CULTURE, BONE MARROW	0.00	0.00	0.00	0.00		XXX
88239		X	TISSUE CULTURE, OTHER	0.00	0.00	0.00	0.00		XXX
88245		X	CHROMOSOME ANALYSIS	0.00	0.00	0.00	0.00		XXX
88248		X	CHROMOSOME ANALYSIS	0.00	0.00	0.00	0.00		XXX
88250		X	CHROMOSOME ANALYSIS	0.00	0.00	0.00	0.00		XXX
88260		X	CHROMOSOME ANALYSIS: 5 CELLS	0.00	0.00	0.00	0.00		XXX
88261		X	CHROMOSOME ANALYSIS: 5 CELLS	0.00	0.00	0.00	0.00		XXX
88262		X	CHROMOSOME COUNT: 15-20 CELLS	0.00	0.00	0.00	0.00		XXX
88263		X	CHROMOSOME ANALYSIS: 45 CELLS	0.00	0.00	0.00	0.00		XXX
88267		X	CHROMOSOME ANALYSIS: PLACENTA	0.00	0.00	0.00	0.00		XXX
88269		X	CHROMOSOME ANALYSIS: AMNIOTIC	0.00	0.00	0.00	0.00		XXX
88280		X	CHROMOSOME KARYOTYPE STUDY	0.00	0.00	0.00	0.00		XXX
88283		X	CHROMOSOME BANDING STUDY	0.00	0.00	0.00	0.00		XXX
88285		X	CHROMOSOME COUNT: ADDITIONAL	0.00	0.00	0.00	0.00		XXX
88289		X	CHROMOSOME STUDY: ADDITIONAL	0.00	0.00	0.00	0.00		XXX
88299		C	CYTOGENETIC STUDY	0.00	0.00	0.00	0.00		XXX
88300		A	TISSUE EXAM BY PATHOLOGIST	0.08	0.17	0.01	0.26	1	XXX
88300	TC	A	TISSUE EXAM BY PATHOLOGIST	0.00	0.05	0.00	0.05		XXX
88300	26	A	TISSUE EXAM BY PATHOLOGIST	0.08	0.12	0.01	0.21	1	XXX
88302		A	TISSUE EXAM BY PATHOLOGIST	0.13	0.39	0.03	0.55	1	XXX
88302	TC	A	TISSUE EXAM BY PATHOLOGIST	0.00	0.12	0.01	0.13		XXX
88302	26	A	TISSUE EXAM BY PATHOLOGIST	0.13	0.27	0.02	0.42	1	XXX
88304		A	TISSUE EXAM BY PATHOLOGIST	0.23	0.53	0.03	0.79	1	XXX
88304	TC	A	TISSUE EXAM BY PATHOLOGIST	0.00	0.17	0.01	0.18		XXX
88304	26	A	TISSUE EXAM BY PATHOLOGIST	0.23	0.36	0.02	0.61	1	XXX
88305		A	TISSUE EXAM BY PATHOLOGIST	0.79	0.84	0.06	1.69	1	XXX
88305	TC	A	TISSUE EXAM BY PATHOLOGIST	0.00	0.27	0.02	0.29		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
88305	26	A	TISSUE EXAM BY PATHOLOGIST	0.79	0.57	0.04	1.40	1	XXX
88307		A	TISSUE EXAM BY PATHOLOGIST	1.68	1.21	0.09	2.98	1	XXX
88307	TC	A	TISSUE EXAM BY PATHOLOGIST	0.00	0.39	0.03	0.42		XXX
88307	26	A	TISSUE EXAM BY PATHOLOGIST	1.68	0.82	0.06	2.56	1	XXX
88309		A	TISSUE EXAM BY PATHOLOGIST	2.41	1.53	0.10	4.04	1	XXX
88309	TC	A	TISSUE EXAM BY PATHOLOGIST	0.00	0.49	0.03	0.52		XXX
88309	26	A	TISSUE EXAM BY PATHOLOGIST	2.41	1.04	0.07	3.52	1	XXX
88311		A	DECALCIFY TISSUE	0.25	0.16	0.01	0.42	3	XXX
88311	TC	A	DECALCIFY TISSUE	0.00	0.05	0.00	0.05		XXX
88311	26	A	DECALCIFY TISSUE	0.25	0.11	0.01	0.37	3	XXX
88312		A	SPECIAL STAINS	0.30	0.20	0.01	0.51	3	XXX
88312	TC	A	SPECIAL STAINS	0.00	0.06	0.00	0.06		XXX
88312	26	A	SPECIAL STAINS	0.30	0.14	0.01	0.45	3	XXX
88313		A	SPECIAL STAINS	0.25	0.16	0.01	0.42	3	XXX
88313	TC	A	SPECIAL STAINS	0.00	0.05	0.00	0.05		XXX
88313	26	A	SPECIAL STAINS	0.25	0.11	0.01	0.37	3	XXX
88314		A	HISTOCHEMICAL STAIN	0.63	0.50	0.03	1.16	3	XXX
88314	TC	A	HISTOCHEMICAL STAIN	0.00	0.14	0.01	0.15		XXX
88314	26	A	HISTOCHEMICAL STAIN	0.63	0.36	0.02	1.01	3	XXX
88318		A	CHEMICAL HISTOCHEMISTRY	0.29	0.18	0.01	0.48	3	XXX
88318	TC	A	CHEMICAL HISTOCHEMISTRY	0.00	0.06	0.00	0.06		XXX
88318	26	A	CHEMICAL HISTOCHEMISTRY	0.29	0.12	0.01	0.42	3	XXX
88319		A	ENZYME HISTOCHEMISTRY	0.57	0.39	0.03	0.99	3	XXX
88319	TC	A	ENZYME HISTOCHEMISTRY	0.00	0.12	0.01	0.13		XXX
88319	26	A	ENZYME HISTOCHEMISTRY	0.57	0.27	0.02	0.86	3	XXX
88321		A	MICROSLIDE CONSULTATION	0.37	0.43	0.03	0.83	2	XXX
88323		A	MICROSLIDE CONSULTATION	0.37	0.58	0.04	0.99	2	XXX
88323	TC	A	MICROSLIDE CONSULTATION	0.00	0.17	0.01	0.18		XXX
88323	26	A	MICROSLIDE CONSULTATION	0.37	0.41	0.03	0.81	2	XXX
88325		A	COMPREHENSIVE REVIEW OF DATA	1.13	0.50	0.04	1.67	2	XXX
88329		A	PATHOLOGY CONSULT IN SURGERY	0.58	0.38	0.03	0.99	2	XXX
88331		A	PATHOLOGY CONSULT IN SURGERY	0.96	0.89	0.06	1.91	2	XXX
88331	TC	A	PATHOLOGY CONSULT IN SURGERY	0.00	0.29	0.02	0.31		XXX
88331	26	A	PATHOLOGY CONSULT IN SURGERY	0.96	0.60	0.04	1.60	2	XXX
88332		A	PATHOLOGY CONSULT IN SURGERY	0.38	0.44	0.03	0.85	2	XXX
88332	TC	A	PATHOLOGY CONSULT IN SURGERY	0.00	0.14	0.01	0.15		XXX
88332	26	A	PATHOLOGY CONSULT IN SURGERY	0.38	0.30	0.02	0.70	2	XXX
88342		A	IMMUNOCYTOCHEMISTRY	0.19	0.50	0.03	0.72	2	XXX
88342	TC	A	IMMUNOCYTOCHEMISTRY	0.00	0.16	0.01	0.17		XXX
88342	26	A	IMMUNOCYTOCHEMISTRY	0.19	0.34	0.02	0.55	2	XXX
88346		A	IMMUNOFUORESCENT STUDY	0.19	0.46	0.03	0.68	2	XXX
88346	TC	A	IMMUNOFUORESCENT STUDY	0.00	0.14	0.01	0.15		XXX
88346	26	A	IMMUNOFUORESCENT STUDY	0.19	0.32	0.02	0.53	2	XXX
88347		A	IMMUNOFUORESCENT STUDY	0.19	0.29	0.03	0.51	2	XXX
88347	TC	A	IMMUNOFUORESCENT STUDY	0.00	0.14	0.01	0.15		XXX
88347	26	A	IMMUNOFUORESCENT STUDY	0.19	0.15	0.02	0.36	2	XXX
88348		A	ELECTRON MICROSCOPY	1.59	1.82	0.12	3.53	2	XXX
88348	TC	A	ELECTRON MICROSCOPY	0.00	0.57	0.04	0.61		XXX
88348	26	A	ELECTRON MICROSCOPY	1.59	1.25	0.08	2.92	2	XXX
88349		A	SCANNING ELECTRON MICROSCOPY	0.80	1.23	0.09	2.12	2	XXX
88349	TC	A	SCANNING ELECTRON MICROSCOPY	0.00	0.40	0.03	0.43		XXX
88349	26	A	SCANNING ELECTRON MICROSCOPY	0.80	0.83	0.06	1.69	2	XXX
88355		A	ANALYSIS, SKELETAL MUSCLE	1.94	1.40	0.10	3.44	3	XXX
88355	TC	A	ANALYSIS, SKELETAL MUSCLE	0.00	0.43	0.03	0.46		XXX
88355	26	A	ANALYSIS, SKELETAL MUSCLE	1.94	0.97	0.07	2.98	3	XXX
88356		A	ANALYSIS, NERVE	3.18	2.14	0.14	5.46	3	XXX
88356	TC	A	ANALYSIS, NERVE	0.00	0.67	0.04	0.71		XXX
88356	26	A	ANALYSIS, NERVE	3.18	1.47	0.10	4.75	3	XXX
88358		A	ANALYSIS, TUMOR	2.97	1.83	0.12	4.92	3	XXX
88358	TC	A	ANALYSIS, TUMOR	0.00	0.61	0.04	0.65		XXX
88358	26	A	ANALYSIS, TUMOR	2.97	1.22	0.08	4.27	3	XXX
88362		A	NERVE TEASING PREPARATIONS	2.28	1.56	0.10	3.94	3	XXX
88362	TC	A	NERVE TEASING PREPARATIONS	0.00	0.51	0.03	0.54		XXX
88362	26	A	NERVE TEASING PREPARATIONS	2.28	1.05	0.07	3.40	3	XXX
88365		A	TISSUE HYBRIDIZATION	0.98	0.59	0.04	1.61	3	XXX
88365	TC	A	TISSUE HYBRIDIZATION	0.00	0.19	0.01	0.20		XXX
88365	26	A	TISSUE HYBRIDIZATION	0.98	0.40	0.03	1.41	3	XXX
88399		C	SURGICAL PATHOLOGY PROCEDURE	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
89050		X	BODY FLUID CELL COUNT	0.00	0.00	0.00	0.00		XXX
89051		X	BODY FLUID CELL COUNT	0.00	0.00	0.00	0.00		XXX
89060		X	EXAM, SYNOVIAL FLUID CRYSTALS	0.00	0.00	0.00	0.00		XXX
89060	26	A	EXAM, SYNOVIAL FLUID CRYSTALS	0.38	0.21	0.01	0.60	2	XXX
89100		A	SAMPLE INTESTINAL CONTENTS	0.64	0.44	0.03	1.11	3	XXX
89105		A	SAMPLE INTESTINAL CONTENTS	0.54	0.41	0.03	0.98	3	XXX
89125		X	SPECIMEN FAT STAIN	0.00	0.00	0.00	0.00		XXX
89130		A	SAMPLE STOMACH CONTENTS	0.47	0.43	0.03	0.93	3	XXX
89132		A	SAMPLE STOMACH CONTENTS	0.20	0.20	0.02	0.42	3	XXX
89135		A	SAMPLE STOMACH CONTENTS	0.83	0.62	0.04	1.49	3	XXX
89136		A	SAMPLE STOMACH CONTENTS	0.22	0.23	0.02	0.47	3	XXX
89140		A	SAMPLE STOMACH CONTENTS	0.99	0.85	0.07	1.91	3	XXX
89141		A	SAMPLE STOMACH CONTENTS	0.90	0.77	0.06	1.73	3	XXX
89160		X	EXAM FECES FOR MEAT FIBERS	0.00	0.00	0.00	0.00		XXX
89190		X	NASAL SMEAR FOR EOSINOPHILS	0.00	0.00	0.00	0.00		XXX
89205		X	OCCULT BLOOD TEST	0.00	0.00	0.00	0.00		XXX
89300		X	SEMEN ANALYSIS	0.00	0.00	0.00	0.00		XXX
89310		X	SEMEN ANALYSIS	0.00	0.00	0.00	0.00		XXX
89320		X	SEMEN ANALYSIS	0.00	0.00	0.00	0.00		XXX
89325		X	SPERM ANTIBODY TEST	0.00	0.00	0.00	0.00		XXX
89329		X	SPERM EVALUATION TEST	0.00	0.00	0.00	0.00		XXX
89330		X	EVALUATION, CERVICAL MUCUS	0.00	0.00	0.00	0.00		XXX
89350		A	SPUTUM SPECIMEN COLLECTION	0.00	0.41	0.03	0.44		XXX
89355		X	EXAM FECES FOR STARCH	0.00	0.00	0.00	0.00		XXX
89360		A	COLLECT SWEAT FOR TEST	0.00	0.45	0.03	0.48		XXX
89365		X	WATER LOAD TEST	0.00	0.00	0.00	0.00		XXX
89399		C	PATHOLOGY LAB PROCEDURE	0.00	0.00	0.00	0.00		XXX
90000		V	OFFICE/OP VISIT, NEW, BRIEF	0.00	0.00	0.00	0.00		XXX
90010		V	OFFICE/OP VISIT, NEW, LTD	0.00	0.00	0.00	0.00		XXX
90015		V	OFFICE/OP VISIT, NEW, INTERM	0.00	0.00	0.00	0.00		XXX
90017		V	OFFICE/OP VISIT, NEW, EXTEND	0.00	0.00	0.00	0.00		XXX
90020		V	OFFICE/OP VISIT, NEW, COMPRH	0.00	0.00	0.00	0.00		XXX
90030		V	OFFICE/OP VISIT, EST, MINIM	0.00	0.00	0.00	0.00		XXX
90040		V	OFFICE/OP VISIT, EST, BRIEF	0.00	0.00	0.00	0.00		XXX
90050		V	OFFICE/OP VISIT, EST, LTD	0.00	0.00	0.00	0.00		XXX
90060		V	OFFICE/OP VISIT, EST, INTERM	0.00	0.00	0.00	0.00		XXX
90070		V	OFFICE/OP VISIT, EST, EXTEND	0.00	0.00	0.00	0.00		XXX
90080		V	OFFICE/OP VISIT, EST, COMPRH	0.00	0.00	0.00	0.00		XXX
90100		V	HOME VISIT, NEW, BRIEF	0.00	0.00	0.00	0.00		XXX
90110		V	HOME VISIT, NEW, LIMITED	0.00	0.00	0.00	0.00		XXX
90115		V	HOME VISIT, NEW, INTERMED.	0.00	0.00	0.00	0.00		XXX
90117		V	HOME VISIT, NEW, EXTENDED	0.00	0.00	0.00	0.00		XXX
90130		V	HOME VISIT, MINIMAL	0.00	0.00	0.00	0.00		XXX
90140		V	HOME VISIT, BRIEF	0.00	0.00	0.00	0.00		XXX
90150		V	HOME VISIT, LIMITED	0.00	0.00	0.00	0.00		XXX
90160		V	HOME VISIT, INTERMED.	0.00	0.00	0.00	0.00		XXX
90170		V	HOME VISIT, EXTENDED	0.00	0.00	0.00	0.00		XXX
90200		V	HOSPITAL CARE, NEW, BRIEF	0.00	0.00	0.00	0.00		XXX
90215		V	HOSPITAL CARE, NEW, INTERMED.	0.00	0.00	0.00	0.00		XXX
90220		V	HOSPITAL CARE, NEW, COMPREH.	0.00	0.00	0.00	0.00		XXX
90225		D	HOSPITAL CARE, NEW, NEWBORN	0.00	0.00	0.00	0.00		XXX
90240		V	HOSPITAL VISIT, BRIEF	0.00	0.00	0.00	0.00		XXX
90250		V	HOSPITAL VISIT, LIMITED	0.00	0.00	0.00	0.00		XXX
90260		V	HOSPITAL VISIT, INTERMEDIATE	0.00	0.00	0.00	0.00		XXX
90270		V	HOSPITAL VISIT, EXTENDED	0.00	0.00	0.00	0.00		XXX
90280		V	HOSPITAL VISIT, COMPREHENSIVE	0.00	0.00	0.00	0.00		XXX
90282		D	NORMAL NEWBORN CARE, HOSPITAL	0.00	0.00	0.00	0.00		XXX
90292		V	HOSPITAL DISCHARGE DAY	0.00	0.00	0.00	0.00		XXX
90300		V	CARE FACILITY VISIT, BRIEF	0.00	0.00	0.00	0.00		XXX
90315		V	CARE FACILITY VISIT, INTERMED	0.00	0.00	0.00	0.00		XXX
90320		V	CARE FACILITY VISIT, COMPRH.	0.00	0.00	0.00	0.00		XXX
90340		V	CARE FACILITY VISIT, BRIEF	0.00	0.00	0.00	0.00		XXX
90350		V	CARE FACILITY VISIT, LIMITED	0.00	0.00	0.00	0.00		XXX
90360		V	CARE FACILITY VISIT, INTERMED	0.00	0.00	0.00	0.00		XXX
90370		V	CARE FACILITY VISIT, EXTEND.	0.00	0.00	0.00	0.00		XXX
90400		V	CARE FACILITY VISIT, BRIEF	0.00	0.00	0.00	0.00		XXX
90410		V	CARE FACILITY VISIT, LIMITED	0.00	0.00	0.00	0.00		XXX
90415		V	CARE FACILITY VISIT, INTERMED	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
90420		V	CARE FACILITY VISIT, COMPRH.	0.00	0.00	0.00	0.00		XXX
90430		V	CARE FACILITY VISIT, MINIMAL	0.00	0.00	0.00	0.00		XXX
90440		V	CARE FACILITY VISIT, BRIEF	0.00	0.00	0.00	0.00		XXX
90450		V	CARE FACILITY VISIT, LIMITED	0.00	0.00	0.00	0.00		XXX
90460		V	CARE FACILITY VISIT, INTERMED	0.00	0.00	0.00	0.00		XXX
90470		V	CARE FACILITY VISIT, EXTEND.	0.00	0.00	0.00	0.00		XXX
90500		V	EMERGENCY CARE, NEW, MINIMAL	0.00	0.00	0.00	0.00		XXX
90505		V	EMERGENCY CARE, NEW, BRIEF	0.00	0.00	0.00	0.00		XXX
90510		V	EMERGENCY CARE, NEW, LIMITED	0.00	0.00	0.00	0.00		XXX
90515		V	EMERGENCY CARE, NEW, INTERMED	0.00	0.00	0.00	0.00		XXX
90517		V	EMERGENCY CARE, NEW, EXTEND.	0.00	0.00	0.00	0.00		XXX
90520		V	EMERGENCY CARE, NEW, COMPRH	0.00	0.00	0.00	0.00		XXX
90530		V	EMERGENCY CARE, MINIMAL	0.00	0.00	0.00	0.00		XXX
90540		V	EMERGENCY CARE, BRIEF	0.00	0.00	0.00	0.00		XXX
90550		V	EMERGENCY CARE, LIMITED	0.00	0.00	0.00	0.00		XXX
90560		V	EMERGENCY CARE, INTERMEDIATE	0.00	0.00	0.00	0.00		XXX
90570		V	EMERGENCY CARE, EXTENDED	0.00	0.00	0.00	0.00		XXX
90580		V	EMERGENCY CARE, COMPREHENSIVE	0.00	0.00	0.00	0.00		XXX
90590		V	ADVANCED LIFE SUPPORT	0.00	0.00	0.00	0.00		XXX
90600		V	LIMITED CONSULTATION	0.00	0.00	0.00	0.00		XXX
90605		V	INTERMEDIATE CONSULTATION	0.00	0.00	0.00	0.00		XXX
90610		V	EXTENDED CONSULTATION	0.00	0.00	0.00	0.00		XXX
90620		V	COMPREHENSIVE CONSULTATION	0.00	0.00	0.00	0.00		XXX
90630		V	COMPLEX CONSULTATION	0.00	0.00	0.00	0.00		XXX
90640		V	BRIEF FOLLOW-UP CONSULT	0.00	0.00	0.00	0.00		XXX
90641		V	LIMITED FOLLOW-UP CONSULT	0.00	0.00	0.00	0.00		XXX
90642		V	INTERMEDIATE FOLLOWUP CONSULT	0.00	0.00	0.00	0.00		XXX
90643		V	COMPLEX FOLLOW-UP CONSULT	0.00	0.00	0.00	0.00		XXX
90650		V	2ND OR 3RD OPINION	0.00	0.00	0.00	0.00		XXX
90651		V	2ND OR 3RD OPINION	0.00	0.00	0.00	0.00		XXX
90652		V	2ND OR 3RD OPINION	0.00	0.00	0.00	0.00		XXX
90653		V	2ND OR 3RD OPINION	0.00	0.00	0.00	0.00		XXX
90654		V	2ND OR 3RD OPINION	0.00	0.00	0.00	0.00		XXX
90699		V	GENERAL MEDICAL SERVICE	0.00	0.00	0.00	0.00		XXX
90701		E	DTP IMMUNIZATION	0.00	0.00	0.00	0.00		XXX
90702		E	DT IMMUNIZATION	0.00	0.00	0.00	0.00		XXX
90703		E	TETANUS IMMUNIZATION	0.00	0.00	0.00	0.00		XXX
90704		E	MUMPS IMMUNIZATION	0.00	0.00	0.00	0.00		XXX
90705		E	MEASLES IMMUNIZATION	0.00	0.00	0.00	0.00		XXX
90706		E	RUBELLA IMMUNIZATION	0.00	0.00	0.00	0.00		XXX
90707		E	MMR VIRUS IMMUNIZATION	0.00	0.00	0.00	0.00		XXX
90708		E	MEASLES-RUBELLA IMMUNIZATION	0.00	0.00	0.00	0.00		XXX
90709		E	RUBELLA & MUMPS IMMUNIZATION	0.00	0.00	0.00	0.00		XXX
90712		E	ORAL POLIOVIRUS IMMUNIZATION	0.00	0.00	0.00	0.00		XXX
90713		E	POLIOMYELITIS IMMUNIZATION	0.00	0.00	0.00	0.00		XXX
90714		E	TYPHOID IMMUNIZATION	0.00	0.00	0.00	0.00		XXX
90717		E	YELLOW FEVER IMMUNIZATION	0.00	0.00	0.00	0.00		XXX
90718		E	TD IMMUNIZATION	0.00	0.00	0.00	0.00		XXX
90719		E	DIPHTHERIA IMMUNIZATION	0.00	0.00	0.00	0.00		XXX
90724		E	INFLUENZA IMMUNIZATION	0.00	0.00	0.00	0.00		XXX
90725		N	CHOLERA IMMUNIZATION	0.00	0.00	0.00	0.00		XXX
90726		E	RABIES IMMUNIZATION	0.00	0.00	0.00	0.00		XXX
90727		E	PLAGUE IMMUNIZATION	0.00	0.00	0.00	0.00		XXX
90728		E	BCG IMMUNIZATION	0.00	0.00	0.00	0.00		XXX
90731		E	HEPATITIS B IMMUNIZATION	0.00	0.00	0.00	0.00		XXX
90732		E	PNEUMOCOCCAL IMMUNIZATION	0.00	0.00	0.00	0.00		XXX
90733		E	MENINGOCOCCAL IMMUNIZATION	0.00	0.00	0.00	0.00		XXX
90737		E	INFLUENZA B IMMUNIZATION	0.00	0.00	0.00	0.00		XXX
90741		E	PASSIVE IMMUNIZATION, ISG	0.00	0.00	0.00	0.00		XXX
90742		E	SPECIAL PASSIVE IMMUNIZATION	0.00	0.00	0.00	0.00		XXX
90749		C	IMMUNIZATION PROCEDURE	0.00	0.00	0.00	0.00		XXX
90750		V	PREVENTIVE MEDICINE, ADULT	0.00	0.00	0.00	0.00		XXX
90751		V	PREVENTIVE MEDICINE, 12-17	0.00	0.00	0.00	0.00		XXX
90752		V	PREVENTIVE MEDICINE, 5-11	0.00	0.00	0.00	0.00		XXX
90753		V	PREVENTIVE MEDICINE, 1-4	0.00	0.00	0.00	0.00		XXX
90754		V	PREVENTIVE MEDICINE, INFANT	0.00	0.00	0.00	0.00		XXX
90755		V	INFANT CARE TO AGE ONE YEAR	0.00	0.00	0.00	0.00		XXX
90757		V	NEWBORN CARE NOT IN HOSPITAL	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
90760		V	PREVENTIVE MEDICINE, ADULT	0.00	0.00	0.00	0.00		XXX
90761		V	PREVENTIVE MEDICINE, 12-17	0.00	0.00	0.00	0.00		XXX
90762		V	PREVENTIVE MEDICINE, 5-11	0.00	0.00	0.00	0.00		XXX
90763		V	PREVENTIVE MEDICINE, 1-4	0.00	0.00	0.00	0.00		XXX
90764		V	PREVENTIVE MEDICINE, INFANT	0.00	0.00	0.00	0.00		XXX
90774		D	DEVELOPMENT EVALUATION TESTS	0.00	0.00	0.00	0.00		XXX
90778		D	BREATH RECORDING, INFANT	0.00	0.00	0.00	0.00		XXX
90780		A	IV INFUSION THERAPY, 1 HOUR	0.00	1.18	0.09	1.27		XXX
90781		A	IV INFUSION, ADDITIONAL HOUR	0.00	0.60	0.04	0.64		XXX
90782		T	INJECTION (SC)/(IM)	0.00	0.10	0.01	0.11		XXX
90783		T	INJECTION (IA)	0.00	0.41	0.03	0.44		XXX
90784		T	INJECTION (IV)	0.00	0.51	0.04	0.55		XXX
90788		T	INJECTION OF ANTIBIOTIC	0.00	0.11	0.01	0.12		XXX
90798		A	INJECTION FOR SEVERE ALLERGY	0.00	0.41	0.03	0.44		XXX
90799		C	THERAPEUTIC/DIAG INJECTION	0.00	0.00	0.00	0.00		XXX
90801		A	PSYCHIATRIC INTERVIEW	2.12	0.71	0.09	2.92	2	XXX
90820		A	DIAGNOSTIC INTERVIEW	2.20	0.83	0.12	3.15	2	XXX
90825		A	EVALUATION OF TESTS/RECORDS	1.02	0.32	0.04	1.38	1	XXX
90830		A	PSYCHOLOGICAL TESTING	0.00	1.77	0.21	1.98		XXX
90835		A	SPECIAL INTERVIEW	2.97	1.12	0.16	4.25	2	XXX
90841		X	PSYCHOTHERAPY	0.00	0.00	0.00	0.00		XXX
90843		A	PSYCHOTHERAPY, 20-30 MIN	1.06	0.36	0.05	1.47	2	XXX
90844		A	PSYCHOTHERAPY, 45-50 MIN	1.67	0.58	0.08	2.33	2	XXX
90845		A	MEDICAL PSYCHOANALYSIS	1.42	0.54	0.08	2.04	1	XXX
90846		A	SPECIAL FAMILY THERAPY	1.76	0.67	0.09	2.52	1	XXX
90847		A	SPECIAL FAMILY THERAPY	2.12	0.62	0.08	2.82	2	XXX
90849		N	SPECIAL FAMILY THERAPY	0.00	0.00	0.00	0.00		XXX
90853		A	SPECIAL GROUP THERAPY	0.42	0.27	0.03	0.72	2	XXX
90855		A	INDIVIDUAL PSYCHOTHERAPY	1.66	0.63	0.09	2.38	2	XXX
90857		A	SPECIAL GROUP THERAPY	0.42	0.16	0.02	0.60	2	XXX
90862		A	MEDICATION MANAGEMENT	0.85	0.38	0.05	1.28	1	XXX
90870		A	ELECTROCONVULSIVE THERAPY	1.91	0.57	0.08	2.56	2	XXX
90871		A	ELECTROCONVULSIVE THERAPY	2.87	0.87	0.13	3.87	2	XXX
90880		A	MEDICAL HYPNOTHERAPY	2.30	0.68	0.07	3.05	2	XXX
90882		N	ENVIRONMENTAL MANIPULATION	0.00	0.00	0.00	0.00		XXX
90887		A	CONSULTATION WITH FAMILY	1.56	0.34	0.04	1.94	1	XXX
90889		B	PREPARATION OF REPORT	0.00	0.00	0.00	0.00		XXX
90899		N	PSYCHIATRIC SERVICE/THERAPY	0.00	0.00	0.00	0.00		XXX
90900		A	BIOFEEDBACK, ELECTROMYOGRAM	0.94	0.95	0.08	1.97	1	XXX
90902		A	BIOFEEDBACK, NERVE IMPULSE	0.94	0.67	0.05	1.66	2	XXX
90904		A	BIOFEEDBACK, BLOOD PRESSURE	0.94	0.60	0.08	1.62	2	XXX
90906		A	BIOFEEDBACK, BLOOD FLOW	0.94	1.69	0.11	2.74	2	XXX
90908		A	BIOFEEDBACK, BRAIN WAVES	0.94	0.91	0.06	1.91	2	XXX
90910		A	BIOFEEDBACK, OCULOGRAM	0.94	0.71	0.10	1.75	2	XXX
90915		A	BIOFEEDBACK, UNSPECIFIED	0.94	0.80	0.06	1.80	2	XXX
90935		A	HEMODIALYSIS, ONE EVALUATION	0.94	1.52	0.10	2.56	1	XXX
90937		A	HEMODIALYSIS, REPEATED EVAL.	2.18	3.01	0.19	5.38	1	XXX
90945		A	DIALYSIS, ONE EVALUATION	0.92	1.29	0.08	2.29	1	XXX
90947		A	DIALYSIS, REPEATED EVAL.	2.00	2.14	0.14	4.28	1	XXX
90989		X	DIALYSIS TRAINING/COMPLETE	0.00	0.00	0.00	0.00		XXX
90993		X	DIALYSIS TRAINING/INCOMPLETE	0.00	0.00	0.00	0.00		XXX
90995		X	ESRD RELATED SERVICES, MONTH	0.00	0.00	0.00	0.00		XXX
90997		A	HEMOPERFUSION	1.93	2.59	0.16	4.68	2	XXX
90998		X	ESRD RELATED SERVICES, DAY	0.00	0.00	0.00	0.00		XXX
90999		C	DIALYSIS PROCEDURE	0.00	0.00	0.00	0.00		XXX
91000		A	ESOPHAGEAL INTUBATION	1.04	0.70	0.06	1.80	1	000
91000	TC	A	ESOPHAGEAL INTUBATION	0.00	0.07	0.01	0.08		000
91000	26	A	ESOPHAGEAL INTUBATION	1.04	0.63	0.05	1.72	1	000
91010		A	ESOPHAGUS MOTILITY STUDY	1.74	2.41	0.17	4.32	1	000
91010	TC	A	ESOPHAGUS MOTILITY STUDY	0.00	0.83	0.06	0.89		000
91010	26	A	ESOPHAGUS MOTILITY STUDY	1.74	1.58	0.11	3.43	1	000
91011		A	ESOPHAGUS MOTILITY STUDY	2.09	2.77	0.17	5.03	1	000
91011	TC	A	ESOPHAGUS MOTILITY STUDY	0.00	1.00	0.06	1.06		000
91011	26	A	ESOPHAGUS MOTILITY STUDY	2.09	1.77	0.11	3.97	1	000
91012		A	ESOPHAGUS MOTILITY STUDY	2.03	3.28	0.22	5.53	1	000
91012	TC	A	ESOPHAGUS MOTILITY STUDY	0.00	1.15	0.07	1.22		000
91012	26	A	ESOPHAGUS MOTILITY STUDY	2.03	2.13	0.15	4.31	1	000
91020		A	ESOPHAGOGASTRIC STUDY	2.00	2.30	0.16	4.46	1	000

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
91020	TC	A	ESOPHAGOGASTRIC STUDY	0.00	0.44	0.04	0.48		000
91020	26	A	ESOPHAGOGASTRIC STUDY	2.00	1.86	0.12	3.98	1	000
91030		A	ACID PERFUSION OF ESOPHAGUS	1.27	0.73	0.05	2.05	1	000
91030	TC	A	ACID PERFUSION OF ESOPHAGUS	0.00	0.37	0.02	0.39		000
91030	26	A	ACID PERFUSION OF ESOPHAGUS	1.27	0.36	0.03	1.66	1	000
91032		A	ESOPHAGUS, ACID REFLUX TEST	1.68	2.15	0.17	4.00	1	000
91032	TC	A	ESOPHAGUS, ACID REFLUX TEST	0.00	0.83	0.07	0.90		000
91032	26	A	ESOPHAGUS, ACID REFLUX TEST	1.68	1.32	0.10	3.10	1	000
91033		A	PROLONGED ACID REFLUX TEST	1.80	3.03	0.23	5.06	2	000
91033	TC	A	PROLONGED ACID REFLUX TEST	0.00	1.25	0.09	1.34		000
91033	26	A	PROLONGED ACID REFLUX TEST	1.80	1.78	0.14	3.72	2	000
91052		A	GASTRIC ANALYSIS TEST	1.80	0.80	0.06	2.66	2	000
91052	TC	A	GASTRIC ANALYSIS TEST	0.00	0.26	0.02	0.28		000
91052	26	A	GASTRIC ANALYSIS TEST	1.80	0.54	0.04	2.38	2	000
91055		A	GASTRIC INTUBATION FOR SMEAR	1.35	0.94	0.07	2.36	1	000
91055	TC	A	GASTRIC INTUBATION FOR SMEAR	0.00	0.39	0.03	0.42		000
91055	26	A	GASTRIC INTUBATION FOR SMEAR	1.35	0.55	0.04	1.94	1	000
91060		A	GASTRIC SALINE LOAD TEST	0.48	0.75	0.06	1.29	1	000
91060	TC	A	GASTRIC SALINE LOAD TEST	0.00	0.22	0.02	0.24		000
91060	26	A	GASTRIC SALINE LOAD TEST	0.48	0.53	0.04	1.05	1	000
91065		A	BREATH HYDROGEN TEST	0.47	0.90	0.05	1.42	1	000
91065	TC	A	BREATH HYDROGEN TEST	0.00	0.38	0.02	0.40		000
91065	26	A	BREATH HYDROGEN TEST	0.47	0.52	0.03	1.02	1	000
91100		A	PASS INTESTINE BLEEDING TUBE	1.13	0.60	0.05	1.78	1	000
91105		A	GASTRIC INTUBATION TREATMENT	0.38	0.59	0.04	1.01	2	000
91122		A	ANAL PRESSURE RECORD	1.86	1.73	0.22	3.81	2	000
91122	TC	A	ANAL PRESSURE RECORD	0.00	0.62	0.09	0.71		000
91122	26	A	ANAL PRESSURE RECORD	1.86	1.11	0.13	3.10	2	000
91299		C	GASTROENTEROLOGY PROCEDURE	0.00	0.00	0.00	0.00		XXX
92002		A	EYE EXAM, NEW PATIENT	1.06	0.52	0.02	1.60	2	XXX
92004		A	EYE EXAM, NEW PATIENT	1.70	0.61	0.02	2.33	2	XXX
92012		A	EYE EXAM, ESTABLISHED PATIENT	0.86	0.46	0.02	1.34	1	XXX
92014		A	EYE EXAM, ESTABLISHED PATIENT	1.11	0.58	0.02	1.71	1	XXX
92015		N	DETERMINE REFRACTIVE STATE	0.00	0.00	0.00	0.00		XXX
92018		A	NEW EYE EXAM & TREATMENT	1.59	0.50	0.03	2.12	2	XXX
92019		A	EYE EXAM & TREATMENT	1.38	0.50	0.03	1.91	2	XXX
92020		A	SPECIAL EYE EVALUATION	0.38	0.30	0.01	0.69	2	XXX
92060		A	SPECIAL EYE EVALUATION	0.53	0.41	0.02	0.96	2	XXX
92065		A	ORTHOPTIC/PLEOPTIC TRAINING	0.38	0.37	0.01	0.76	2	XXX
92070		A	FITTING OF CONTACT LENS	0.74	1.27	0.06	2.07	2	XXX
92081		A	VISUAL FIELD EXAMINATION(S)	0.37	0.33	0.01	0.71	2	XXX
92082		A	VISUAL FIELD EXAMINATION(S)	0.46	0.51	0.02	0.99	1	XXX
92083		A	VISUAL FIELD EXAMINATION(S)	0.54	0.88	0.04	1.46	1	XXX
92100		A	SERIAL TONOMETRY EXAM(S)	0.44	0.26	0.01	0.71	1	XXX
92120		A	TONOGRAPHY & EYE EVALUATION	0.85	0.32	0.02	1.19	2	XXX
92130		A	WATER PROVOCATION TONOGRAPHY	0.85	0.52	0.02	1.39	2	XXX
92140		A	GLAUCOMA PROVOCATIVE TESTS	0.53	0.31	0.01	0.85	2	XXX
92225		A	SPECIAL EYE EXAM, INITIAL	0.62	0.48	0.02	1.12	1	XXX
92226		A	SPECIAL EYE EXAM, SUBSEQ	0.53	0.42	0.02	0.97	2	XXX
92230		A	EYE EXAM WITH PHOTOS	0.64	0.73	0.04	1.41	2	XXX
92235		A	EYE EXAM WITH PHOTOS	0.85	1.67	0.09	2.61	2	XXX
92250		A	EYE EXAM WITH PHOTOS	0.46	0.44	0.02	0.92	2	XXX
92260		A	OPHTHALMOSCOPY/DYNAMOMETRY	0.53	0.58	0.03	1.14	2	XXX
92265		A	EYE MUSCLE EVALUATION	0.85	0.30	0.02	1.17	2	XXX
92270		A	ELECTRO-OCULOGRAPHY	0.85	0.69	0.05	1.59	2	XXX
92275		A	ELECTRORETINOGRAPHY	1.06	0.96	0.05	2.07	2	XXX
92280		A	SPECIAL EYE EVALUATION	0.34	0.88	0.05	1.27	1	XXX
92283		A	COLOR VISION EXAMINATION	0.27	0.30	0.01	0.58	2	XXX
92284		A	DARK ADAPTATION EYE EXAM	0.38	0.46	0.02	0.86	2	XXX
92285		A	EYE PHOTOGRAPHY	0.21	0.30	0.01	0.52	2	XXX
92286		A	INTERNAL EYE PHOTOGRAPHY	0.70	1.28	0.07	2.05	1	XXX
92287		A	INTERNAL EYE PHOTOGRAPHY	0.85	1.60	0.08	2.53	2	XXX
92310		N	CONTACT LENS FITTING	0.00	0.00	0.00	0.00		XXX
92311		A	CONTACT LENS FITTING	1.13	0.95	0.03	2.11	2	XXX
92312		A	CONTACT LENS FITTING	1.33	1.22	0.03	2.58	2	XXX
92313		A	CONTACT LENS FITTING	0.97	0.93	0.03	1.93	2	XXX
92314		N	PRESCRIPTION OF CONTACT LENS	0.00	0.00	0.00	0.00		XXX
92315		A	PRESCRIPTION OF CONTACT LENS	0.48	0.70	0.03	1.21	2	XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPs*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
92316		A	PRESCRIPTION OF CONTACT LENS	0.72	1.00	0.04	1.76	2	XXX
92317		A	PRESCRIPTION OF CONTACT LENS	0.48	0.41	0.02	0.91	2	XXX
92325		A	MODIFICATION OF CONTACT LENS	0.00	0.39	0.01	0.40		XXX
92326		A	REPLACEMENT OF CONTACT LENS	0.00	1.65	0.06	1.71		XXX
92330		A	FITTING OF ARTIFICIAL EYE	1.13	1.19	0.09	2.41	2	XXX
92335		A	FITTING OF ARTIFICIAL EYE	0.48	2.08	0.11	2.67	2	XXX
92340		N	FITTING OF SPECTACLES	0.00	0.00	0.00	0.00		XXX
92341		N	FITTING OF SPECTACLES	0.00	0.00	0.00	0.00		XXX
92342		N	FITTING OF SPECTACLES	0.00	0.00	0.00	0.00		XXX
92352		A	SPECIAL SPECTACLES FITTING	0.38	0.31	0.01	0.70	2	XXX
92353		A	SPECIAL SPECTACLES FITTING	0.53	0.42	0.01	0.96	2	XXX
92354		A	SPECIAL SPECTACLES FITTING	0.00	8.89	0.10	8.99		XXX
92355		A	SPECIAL SPECTACLES FITTING	0.00	4.35	0.01	4.36		XXX
92358		A	EYE PROSTHESIS SERVICE	0.00	0.97	0.05	1.02		XXX
92370		N	REPAIR & ADJUST SPECTACLES	0.00	0.00	0.00	0.00		XXX
92371		A	REPAIR & ADJUST SPECTACLES	0.00	0.63	0.02	0.65		XXX
92390		N	SUPPLY OF SPECTACLES	0.00	0.00	0.00	0.00		XXX
92391		N	SUPPLY OF CONTACT LENSES	0.00	0.00	0.00	0.00		XXX
92392		A	SUPPLY OF LOW VISION AIDS	0.00	4.05	0.02	4.07		XXX
92393		A	SUPPLY OF ARTIFICIAL EYE	0.00	12.60	0.71	13.31		XXX
92395		A	SUPPLY OF SPECTACLES	0.00	1.38	0.10	1.48		XXX
92396		A	SUPPLY OF CONTACT LENSES	0.00	2.30	0.08	2.38		XXX
92499		C	EYE SERVICE OR PROCEDURE	0.00	0.00	0.00	0.00		XXX
92502		A	EAR AND THROAT EXAMINATION	1.59	1.17	0.12	2.88	2	000
92504		A	EAR MICROSCOPY EXAMINATION	0.19	0.27	0.02	0.48	2	XXX
92506		A	SPEECH & HEARING EVALUATION	0.91	0.56	0.05	1.52	2	XXX
92507		A	SPEECH/HEARING THERAPY	0.56	0.34	0.03	0.93	2	XXX
92508		A	SPEECH/HEARING THERAPY	0.27	0.19	0.02	0.48	2	XXX
92511		A	NASOPHARYNGOSCOPY	0.88	0.89	0.09	1.86	1	000
92512		A	NASAL FUNCTION STUDIES	0.59	0.50	0.05	1.14	2	XXX
92516		A	FACIAL NERVE FUNCTION TEST	0.45	0.41	0.04	0.90	2	XXX
92520		A	LARYNGEAL FUNCTION STUDIES	0.80	0.57	0.05	1.42	2	XXX
92531		B	SPONTANEOUS NYSTAGMUS STUDY	0.00	0.00	0.00	0.00		XXX
92532		B	POSITIONAL NYSTAGMUS STUDY	0.00	0.00	0.00	0.00		XXX
92533		B	CALORIC VESTIBULAR TEST	0.00	0.00	0.00	0.00		XXX
92534		B	OPTOKINETIC NYSTAGMUS	0.00	0.00	0.00	0.00		XXX
92541		A	SPONTANEOUS NYSTAGMUS TEST	0.42	0.81	0.08	1.31	1	XXX
92541	TC	A	SPONTANEOUS NYSTAGMUS TEST	0.00	0.33	0.03	0.36		XXX
92541	26	A	SPONTANEOUS NYSTAGMUS TEST	0.42	0.48	0.05	0.95	1	XXX
92542		A	POSITIONAL NYSTAGMUS TEST	0.34	0.56	0.06	0.96	2	XXX
92542	TC	A	POSITIONAL NYSTAGMUS TEST	0.00	0.19	0.02	0.21		XXX
92542	26	A	POSITIONAL NYSTAGMUS TEST	0.34	0.37	0.04	0.75	2	XXX
92543		A	CALORIC VESTIBULAR TEST	0.39	0.72	0.08	1.19	2	XXX
92543	TC	A	CALORIC VESTIBULAR TEST	0.00	0.28	0.03	0.31		XXX
92543	26	A	CALORIC VESTIBULAR TEST	0.39	0.44	0.05	0.88	2	XXX
92544		A	OPTOKINETIC NYSTAGMUS TEST	0.27	0.42	0.04	0.73	2	XXX
92544	TC	A	OPTOKINETIC NYSTAGMUS TEST	0.00	0.14	0.01	0.15		XXX
92544	26	A	OPTOKINETIC NYSTAGMUS TEST	0.27	0.28	0.03	0.58	2	XXX
92545		A	OSCILLATING TRACKING TEST	0.24	0.34	0.03	0.61	2	XXX
92545	TC	A	OSCILLATING TRACKING TEST	0.00	0.13	0.01	0.14		XXX
92545	26	A	OSCILLATING TRACKING TEST	0.24	0.21	0.02	0.47	2	XXX
92546		A	TORSION SWING RECORDING	0.30	0.44	0.04	0.78	2	XXX
92546	TC	A	TORSION SWING RECORDING	0.00	0.13	0.01	0.14		XXX
92546	26	A	TORSION SWING RECORDING	0.30	0.31	0.03	0.64	2	XXX
92547		A	SUPPLEMENTAL ELECTRICAL TEST	0.00	0.57	0.06	0.63		XXX
92551		N	PURE TONE HEARING TEST, AIR	0.00	0.00	0.00	0.00		XXX
92552		A	PURE TONE AUDIOMETRY, AIR	0.00	0.44	0.04	0.48		XXX
92553		A	AUDIOMETRY, AIR & BONE	0.00	0.67	0.07	0.74		XXX
92555		A	SPEECH THRESHOLD AUDIOMETRY	0.00	0.37	0.04	0.41		XXX
92556		A	SPEECH AUDIOMETRY, COMPLETE	0.00	0.58	0.06	0.64		XXX
92557		A	COMPREHENSIVE HEARING TEST	0.00	1.18	0.13	1.31		XXX
92559		N	GROUP AUDIOMETRIC TESTING	0.00	0.00	0.00	0.00		XXX
92560		N	BEKESY AUDIOMETRY, SCREEN	0.00	0.00	0.00	0.00		XXX
92561		A	BEKESY AUDIOMETRY, DIAGNOSIS	0.00	0.72	0.07	0.79		XXX
92562		A	LOUDNESS BALANCE TEST	0.00	0.41	0.04	0.45		XXX
92563		A	TONE DECAY HEARING TEST	0.00	0.37	0.04	0.41		XXX
92564		A	SISI HEARING TEST	0.00	0.47	0.05	0.52		XXX
92565		A	STENGER TEST, PURE TONE	0.00	0.39	0.04	0.43		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
92567		A	TYMPANOMETRY	0.00	0.53	0.06	0.59		XXX
92568		A	ACOUSTIC REFLEX TESTING	0.00	0.37	0.04	0.41		XXX
92569		A	ACOUSTIC REFLEX DECAY TEST	0.00	0.41	0.04	0.45		XXX
92571		A	FILTERED SPEECH HEARING TEST	0.00	0.38	0.04	0.42		XXX
92572		A	STAGGERED SPONDAIC WORD TEST	0.00	0.08	0.01	0.09		XXX
92573		A	LOMBARD TEST	0.00	0.34	0.04	0.38		XXX
92574		A	SWINGING STORY TEST	0.00	1.22	0.09	1.31		XXX
92575		A	SENSORINEURAL ACUITY TEST	0.00	0.30	0.03	0.33		XXX
92576		A	SYNTHETIC SENTENCE TEST	0.00	0.44	0.05	0.49		XXX
92577		A	STENGER TEST, SPEECH	0.00	0.72	0.08	0.80		XXX
92578		A	DELAYED AUDITORY FEEDBACK	0.00	0.56	0.05	0.61		XXX
92580		A	ELECTRODERMAL AUDIOMETRY	0.00	0.68	0.07	0.75		XXX
92582		A	CONDITIONING PLAY AUDIOMETRY	0.00	0.73	0.07	0.80		XXX
92583		A	SELECT PICTURE AUDIOMETRY	0.00	0.89	0.09	0.98		XXX
92584		A	ELECTROCOCHLEOGRAPHY	0.00	2.49	0.26	2.75		XXX
92585		A	BRAINSTEM EVOKED AUDIOMETRY	0.00	3.42	0.31	3.73		XXX
92589		A	AUDITORY FUNCTION TEST(S)	0.00	0.55	0.06	0.61		XXX
92590		N	HEARING AID EXAM, ONE EAR	0.00	0.00	0.00	0.00		XXX
92591		N	HEARING AID EXAM, BOTH EARS	0.00	0.00	0.00	0.00		XXX
92592		N	HEARING AID CHECK, ONE EAR	0.00	0.00	0.00	0.00		XXX
92593		N	HEARING AID CHECK, BOTH EARS	0.00	0.00	0.00	0.00		XXX
92594		N	ELECTRO HEARING AID TEST, ONE	0.00	0.00	0.00	0.00		XXX
92595		N	ELECTRO HEARING AID TEST, BOTH	0.00	0.00	0.00	0.00		XXX
92596		A	EAR PROTECTOR EVALUATION	0.00	0.60	0.06	0.66		XXX
92599		C	ENT PROCEDURE/SERVICE	0.00	0.00	0.00	0.00		XXX
92950		A	HEART/LUNG RESUSCITATION/CPR	2.81	2.40	0.18	5.39	1	000
92953		A	TEMPORARY EXTERNAL PACING	0.24	2.11	0.15	2.50	2	000
92960		A	HEART ELECTROCONVERSION	2.99	1.98	0.16	5.13	2	000
92970		A	CARDIOASSIST, INTERNAL	3.71	3.66	0.43	7.80	2	000
92971		A	CARDIOASSIST, EXTERNAL	1.86	1.16	0.08	3.10	2	000
92975		A	DISSOLVE CLOT, HEART VESSEL	7.64	6.02	0.44	14.10	2	000
92977		A	DISSOLVE CLOT, HEART VESSEL	0.00	8.10	0.58	8.68		XXX
92982		A	CORONARY ARTERY DILATION	10.21	17.29	1.29	28.79	1	000
92984		A	CORONARY ARTERY DILATION	1.91	6.00	0.46	8.37	1	000
92986		A	REVISION OF AORTIC VALVE	21.44	12.68	0.95	35.07	2	000
92990		A	REVISION OF PULMONARY VALVE	17.10	10.11	0.75	27.96	2	000
93000		Z	ELECTROCARDIOGRAM, COMPLETE	0.18	0.61	0.04	0.83	2	XXX
93005		A	ELECTROCARDIOGRAM, TRACING	0.00	0.45	0.03	0.48		XXX
93010		Z	ELECTROCARDIOGRAM REPORT	0.18	0.16	0.01	0.35	1	XXX
93012		A	TRANSMISSION OF ECG	0.00	0.21	0.02	0.23		XXX
93014		A	REPORT ON TRANSMITTED ECG	0.16	0.22	0.02	0.40	2	XXX
93015		A	CARDIOVASCULAR STRESS TEST	0.47	2.53	0.18	3.18	2	XXX
93017		A	CARDIOVASCULAR STRESS TEST	0.00	1.72	0.12	1.84		XXX
93018		A	CARDIOVASCULAR STRESS TEST	0.47	0.81	0.06	1.34	1	XXX
93024		A	CARDIAC DRUG STRESS TEST	1.23	2.55	0.20	3.98	2	XXX
93024	TC	A	CARDIAC DRUG STRESS TEST	0.00	0.77	0.06	0.83		XXX
93024	26	A	CARDIAC DRUG STRESS TEST	1.23	1.78	0.14	3.15	2	XXX
93040		Z	RHYTHM ECG WITH REPORT	0.16	0.26	0.02	0.44	2	XXX
93041		A	RHYTHM ECG, TRACING	0.00	0.14	0.01	0.15		XXX
93042		Z	RHYTHM ECG, REPORT	0.16	0.12	0.01	0.29	1	XXX
93201		A	PHONOCARDIOGRAM & ECG LEAD	0.44	0.68	0.05	1.17	2	XXX
93202		A	PHONOCARDIOGRAM & ECG LEAD	0.00	0.39	0.03	0.42		XXX
93204		A	PHONOCARDIOGRAM & ECG LEAD	0.44	0.29	0.02	0.75	1	XXX
93205		A	SPECIAL PHONOCARDIOGRAM	0.49	0.97	0.07	1.53	1	XXX
93208		A	SPECIAL PHONOCARDIOGRAM	0.00	0.38	0.03	0.41		XXX
93209		A	SPECIAL PHONOCARDIOGRAM	0.49	0.59	0.04	1.12	2	XXX
93210		A	INTRACARDIAC PHONOCARDIOGRAM	0.97	1.20	0.08	2.25	1	XXX
93210	TC	A	INTRACARDIAC PHONOCARDIOGRAM	0.00	0.34	0.02	0.36		XXX
93210	26	A	INTRACARDIAC PHONOCARDIOGRAM	0.97	0.86	0.06	1.89	1	XXX
93220		A	VECTORCARDIOGRAM	0.27	0.85	0.06	1.18	2	XXX
93221		A	VECTORCARDIOGRAM TRACING	0.00	0.38	0.03	0.41		XXX
93222		A	VECTORCARDIOGRAM REPORT	0.27	0.47	0.03	0.77	2	XXX
93224		A	ECG MONITOR/REPORT, 24 HRS	0.56	4.16	0.30	5.02	2	XXX
93225		A	ECG MONITOR/RECORD, 24 HRS	0.00	1.17	0.09	1.26		XXX
93226		A	ECG MONITOR/REPORT, 24 HRS	0.00	2.07	0.15	2.22		XXX
93227		A	ECG MONITOR/REVIEW, 24 HRS	0.56	0.92	0.06	1.54	2	XXX
93230		A	ECG MONITOR/REPORT, 24 HRS	0.56	4.11	0.29	4.96	2	XXX
93231		A	ECG MONITOR/RECORD, 24 HRS	0.00	1.23	0.09	1.32		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
93232		A	ECG MONITOR/REPORT, 24 HRS	0.00	1.75	0.12	1.87		XXX
93233		A	ECG MONITOR/REVIEW, 24 HRS	0.56	1.13	0.08	1.77	2	XXX
93235		A	ECG MONITOR/REPORT, 24 HRS	0.47	2.97	0.20	3.64	2	XXX
93236		A	ECG MONITOR/REPORT, 24 HRS	0.00	2.01	0.14	2.15		XXX
93237		A	ECG MONITOR/REVIEW, 24 HRS	0.47	0.96	0.06	1.49	2	XXX
93255		A	APEXCARDIOGRAPHY	0.18	0.31	0.02	0.51	2	XXX
93255	TC	A	APEXCARDIOGRAPHY	0.00	0.15	0.01	0.16		XXX
93255	26	A	APEXCARDIOGRAPHY	0.18	0.16	0.01	0.35	2	XXX
93268		A	ECG RECORD/REVIEW	0.36	0.93	0.09	1.38	2	XXX
93268	TC	A	ECG RECORD/REVIEW	0.00	0.55	0.06	0.61		XXX
93268	26	A	ECG RECORD/REVIEW	0.36	0.38	0.03	0.77	2	XXX
93278		A	ECG/SIGNAL-AVERAGED	0.36	1.84	0.20	2.40	2	XXX
93278	TC	A	ECG/SIGNAL-AVERAGED	0.00	1.05	0.14	1.19		XXX
93278	26	A	ECG/SIGNAL-AVERAGED	0.36	0.79	0.06	1.21	2	XXX
93280		A	CARDIAC FLUOROSCOPY	0.45	0.85	0.07	1.37	2	XXX
93280	TC	A	CARDIAC FLUOROSCOPY	0.00	0.34	0.03	0.37		XXX
93280	26	A	CARDIAC FLUOROSCOPY	0.45	0.51	0.04	1.00	2	XXX
93307		A	ECHO EXAM OF HEART	0.41	5.02	0.37	5.80	2	XXX
93307	TC	A	ECHO EXAM OF HEART	0.00	3.77	0.28	4.05		XXX
93307	26	A	ECHO EXAM OF HEART	0.41	1.25	0.09	1.75	2	XXX
93308		A	ECHO EXAM OF HEART	0.15	1.43	0.10	1.68	1	XXX
93308	TC	A	ECHO EXAM OF HEART	0.00	0.71	0.05	0.76		XXX
93308	26	A	ECHO EXAM OF HEART	0.15	0.72	0.05	0.92	1	XXX
93312		A	ECHO EXAM OF HEART	0.53	3.51	0.29	4.33	2	XXX
93312	TC	A	ECHO EXAM OF HEART	0.00	2.08	0.17	2.25		XXX
93312	26	A	ECHO EXAM OF HEART	0.53	1.43	0.12	2.08	2	XXX
93320		A	DOPPLER ECHO EXAM, HEART	0.39	2.46	0.18	3.03	2	XXX
93320	TC	A	DOPPLER ECHO EXAM, HEART	0.00	1.73	0.13	1.86		XXX
93320	26	A	DOPPLER ECHO EXAM, HEART	0.39	0.73	0.05	1.17	2	XXX
93321		A	DOPPLER ECHO EXAM, HEART	0.15	0.45	0.03	0.63	2	XXX
93321	TC	A	DOPPLER ECHO EXAM, HEART	0.00	0.16	0.01	0.17		XXX
93321	26	A	DOPPLER ECHO EXAM, HEART	0.15	0.29	0.02	0.46	2	XXX
93325		A	DOPPLER COLOR FLOW	0.00	2.95	0.25	3.20		XXX
93350		A	ECHO EXAM OF HEART	1.20	2.47	0.17	3.84	2	XXX
93350	TC	A	ECHO EXAM OF HEART	0.00	1.63	0.11	1.74		XXX
93350	26	A	ECHO EXAM OF HEART	1.20	0.84	0.06	2.10	2	XXX
93501		A	RIGHT HEART CATHETERIZATION	3.18	19.99	1.56	24.73	2	000
93501	TC	A	RIGHT HEART CATHETERIZATION	0.00	16.18	1.21	17.39		000
93501	26	A	RIGHT HEART CATHETERIZATION	3.18	3.81	0.35	7.34	2	000
93503		A	INSERT/PLACE HEART CATHETER	2.56	2.50	0.37	5.43	2	000
93505		A	BIOPSY OF HEART LINING	4.80	5.11	0.45	10.36	2	000
93505	TC	A	BIOPSY OF HEART LINING	0.00	1.92	0.16	2.08		000
93505	26	A	BIOPSY OF HEART LINING	4.80	3.19	0.29	8.28	2	000
93510		A	LEFT HEART CATHETERIZATION	4.51	33.73	2.51	40.75	2	000
93510	TC	A	LEFT HEART CATHETERIZATION	0.00	29.47	2.20	31.67		000
93510	26	A	LEFT HEART CATHETERIZATION	4.51	4.26	0.31	9.08	2	000
93511		A	LEFT HEART CATHETERIZATION	5.31	32.23	2.41	39.95	2	000
93511	TC	A	LEFT HEART CATHETERIZATION	0.00	29.47	2.20	31.67		000
93511	26	A	LEFT HEART CATHETERIZATION	5.31	2.76	0.21	8.28	2	000
93514		A	LEFT HEART CATHETERIZATION	7.43	34.26	2.59	44.28	2	000
93514	TC	A	LEFT HEART CATHETERIZATION	0.00	29.47	2.20	31.67		000
93514	26	A	LEFT HEART CATHETERIZATION	7.43	4.79	0.39	12.61	2	000
93524		A	LEFT HEART CATHETERIZATION	7.32	42.22	3.14	52.68	2	000
93524	TC	A	LEFT HEART CATHETERIZATION	0.00	37.32	2.79	40.11		000
93524	26	A	LEFT HEART CATHETERIZATION	7.32	4.90	0.35	12.57	2	000
93526		A	RT & LT HEART CATHETERS	6.23	44.42	3.29	53.94	2	000
93526	TC	A	RT & LT HEART CATHETERS	0.00	37.32	2.79	40.11		000
93526	26	A	RT & LT HEART CATHETERS	6.23	7.10	0.50	13.83	2	000
93527		A	RT & LT HEART CATHETERS	7.67	44.85	3.32	55.84	2	000
93527	TC	A	RT & LT HEART CATHETERS	0.00	37.32	2.79	40.11		000
93527	26	A	RT & LT HEART CATHETERS	7.67	7.53	0.53	15.73	2	000
93528		A	RT & LT HEART CATHETERS	9.48	41.99	3.13	54.60	2	000
93528	TC	A	RT & LT HEART CATHETERS	0.00	37.32	2.79	40.11		000
93528	26	A	RT & LT HEART CATHETERS	9.48	4.67	0.34	14.49	2	000
93529		C	RT, LT HEART CATHETERIZATION	0.00	0.00	0.00	0.00		000
93529	TC	A	RT, LT HEART CATHETERIZATION	0.00	37.32	2.79	40.11		000
93529	26	A	RT, LT HEART CATHETERIZATION	5.05	3.09	0.23	8.37	2	000
93536		A	INSERT CIRCULATION ASSIST	5.69	8.35	0.75	14.79	2	000

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
93541		A	INJECTION FOR LUNG ANGIOGRAM	0.21	2.18	0.16	2.55	2	000
93542		A	INJECTION FOR HEART X-RAYS	0.21	2.20	0.16	2.57	2	000
93543		A	INJECTION FOR HEART X-RAYS	0.21	1.57	0.11	1.89	2	000
93544		A	INJECTION FOR AORTOGRAPHY	0.21	1.54	0.11	1.86	2	000
93545		A	INJECTION FOR CORONARY X-RAYS	0.21	3.43	0.25	3.89	2	000
93546		A	HEART CATHETER & ANGIOGRAM	4.72	39.82	2.96	47.50	2	000
93546	TC	A	HEART CATHETER & ANGIOGRAM	0.00	32.99	2.47	35.46		000
93546	26	A	HEART CATHETER & ANGIOGRAM	4.72	6.83	0.49	12.04	2	000
93547		A	HEART CATHETER & ANGIOGRAM	4.94	41.44	3.08	49.46	2	000
93547	TC	A	HEART CATHETER & ANGIOGRAM	0.00	32.99	2.47	35.46		000
93547	26	A	HEART CATHETER & ANGIOGRAM	4.94	8.45	0.61	14.00	2	000
93548		A	HEART CATHETER & ANGIOGRAM	5.15	42.26	3.14	50.55	2	000
93548	TC	A	HEART CATHETER & ANGIOGRAM	0.00	32.99	2.47	35.46		000
93548	26	A	HEART CATHETER & ANGIOGRAM	5.15	9.27	0.67	15.09	2	000
93549		A	HEART CATHETER & ANGIOGRAM	6.65	43.79	3.25	53.69	2	000
93549	TC	A	HEART CATHETER & ANGIOGRAM	0.00	32.99	2.47	35.46		000
93549	26	A	HEART CATHETER & ANGIOGRAM	6.65	10.80	0.78	18.23	2	000
93550		A	HEART CATHETER & ANGIOGRAM	6.87	45.37	3.37	55.61	2	000
93550	TC	A	HEART CATHETER & ANGIOGRAM	0.00	32.99	2.47	35.46		000
93550	26	A	HEART CATHETER & ANGIOGRAM	6.87	12.38	0.90	20.15	2	000
93551		A	X-RAY AORTOCORONARY BYPASS	0.21	1.49	0.11	1.81	2	000
93552		A	HEART CATHETER & ANGIOGRAM	5.15	47.78	3.54	56.47	2	000
93552	TC	A	HEART CATHETER & ANGIOGRAM	0.00	36.87	2.76	39.63		000
93552	26	A	HEART CATHETER & ANGIOGRAM	5.15	10.91	0.78	16.84	2	000
93553		A	HEART CATHETER & ANGIOGRAM	5.36	50.10	3.74	59.20	2	000
93553	TC	A	HEART CATHETER & ANGIOGRAM	0.00	36.87	2.76	39.63		000
93553	26	A	HEART CATHETER & ANGIOGRAM	5.36	13.23	0.98	19.57	2	000
93561		A	CARDIAC OUTPUT MEASUREMENT	1.21	1.28	0.14	2.63	2	000
93561	TC	A	CARDIAC OUTPUT MEASUREMENT	0.00	0.49	0.05	0.54		000
93561	26	A	CARDIAC OUTPUT MEASUREMENT	1.21	0.79	0.09	2.09	2	000
93562		A	CARDIAC OUTPUT MEASUREMENT	0.38	0.89	0.10	1.37	2	000
93562	TC	A	CARDIAC OUTPUT MEASUREMENT	0.00	0.37	0.04	0.41		000
93562	26	A	CARDIAC OUTPUT MEASUREMENT	0.38	0.52	0.06	0.96	2	000
93600		A	BUNDLE OF HIS RECORDING	2.23	5.76	0.42	8.41	2	000
93600	TC	A	BUNDLE OF HIS RECORDING	0.00	2.33	0.17	2.50		000
93600	26	A	BUNDLE OF HIS RECORDING	2.23	3.43	0.25	5.91	2	000
93602		A	INTRA-ATRIAL RECORDING	2.23	2.95	0.22	5.40	2	000
93602	TC	A	INTRA-ATRIAL RECORDING	0.00	1.09	0.08	1.17		000
93602	26	A	INTRA-ATRIAL RECORDING	2.23	1.86	0.14	4.23	2	000
93603		A	RIGHT VENTRICULAR RECORDING	2.23	3.94	0.28	6.45	2	000
93603	TC	A	RIGHT VENTRICULAR RECORDING	0.00	1.64	0.12	1.76		000
93603	26	A	RIGHT VENTRICULAR RECORDING	2.23	2.30	0.16	4.69	2	000
93607		A	RIGHT VENTRICULAR RECORDING	3.44	3.56	0.26	7.26	2	000
93607	TC	A	RIGHT VENTRICULAR RECORDING	0.00	1.24	0.09	1.33		000
93607	26	A	RIGHT VENTRICULAR RECORDING	3.44	2.32	0.17	5.93	2	000
93609		A	MAPPING OF TACHYCARDIA	10.61	8.20	0.60	19.41	2	000
93609	TC	A	MAPPING OF TACHYCARDIA	0.00	4.16	0.31	4.47		000
93609	26	A	MAPPING OF TACHYCARDIA	10.61	4.04	0.29	14.94	2	000
93610		A	INTRA-ATRIAL PACING	3.18	3.66	0.27	7.11	2	000
93610	TC	A	INTRA-ATRIAL PACING	0.00	1.22	0.09	1.31		000
93610	26	A	INTRA-ATRIAL PACING	3.18	2.44	0.18	5.80	2	000
93612		A	INTRAVENTRICULAR PACING	3.18	4.04	0.30	7.52	2	000
93612	TC	A	INTRAVENTRICULAR PACING	0.00	1.57	0.12	1.69		000
93612	26	A	INTRAVENTRICULAR PACING	3.18	2.47	0.18	5.83	2	000
93615		A	ESOPHAGEAL RECORDING	1.04	0.67	0.04	1.75	2	000
93615	TC	A	ESOPHAGEAL RECORDING	0.00	0.31	0.02	0.33		000
93615	26	A	ESOPHAGEAL RECORDING	1.04	0.36	0.02	1.42	2	000
93616		A	ESOPHAGEAL RECORDING	1.57	1.75	0.10	3.42	2	000
93616	TC	A	ESOPHAGEAL RECORDING	0.00	0.31	0.02	0.33		000
93616	26	A	ESOPHAGEAL RECORDING	1.57	1.44	0.08	3.09	2	000
93618		A	HEART RHYTHM PACING	3.18	10.02	0.72	13.92	2	000
93618	TC	A	HEART RHYTHM PACING	0.00	3.61	0.26	3.87		000
93618	26	A	HEART RHYTHM PACING	3.18	6.41	0.46	10.05	2	000
93620		A	ELECTROPHYSIOLOGY EVALUATION	12.21	22.58	1.62	36.41	2	000
93620	TC	A	ELECTROPHYSIOLOGY EVALUATION	0.00	8.32	0.62	8.94		000
93620	26	A	ELECTROPHYSIOLOGY EVALUATION	12.21	14.26	1.00	27.47	2	000
93621		C	ELECTROPHYSIOLOGY EVALUATION	0.00	0.00	0.00	0.00		000
93621	TC	C	ELECTROPHYSIOLOGY EVALUATION	0.00	0.00	0.00	0.00		000

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
93621	26	A	ELECTROPHYSIOLOGY EVALUATION	13.34	7.89	0.59	21.82	2	000
93622		C	ELECTROPHYSIOLOGY EVALUATION	0.00	0.00	0.00	0.00		000
93622	TC	C	ELECTROPHYSIOLOGY EVALUATION	0.00	0.00	0.00	0.00		000
93622	26	A	ELECTROPHYSIOLOGY EVALUATION	13.42	7.94	0.59	21.95	2	000
93623		C	STIMULATION, PACING HEART	0.00	0.00	0.00	0.00		000
93623	TC	C	STIMULATION, PACING HEART	0.00	0.00	0.00	0.00		000
93623	26	A	STIMULATION, PACING HEART	0.53	0.32	0.02	0.87	2	000
93624		A	ELECTROPHYSIOLOGIC STUDY	4.28	5.14	0.37	9.79	2	000
93624	TC	A	ELECTROPHYSIOLOGIC STUDY	0.00	1.99	0.15	2.14		000
93624	26	A	ELECTROPHYSIOLOGIC STUDY	4.28	3.15	0.22	7.65	2	000
93631		A	HEART PACING, MAPPING	6.10	12.90	1.25	20.25	2	000
93631	TC	A	HEART PACING, MAPPING	0.00	0.28	0.03	0.31		000
93631	26	A	HEART PACING, MAPPING	6.10	12.62	1.22	19.94	2	000
93640		A	EVALUATION HEART DEVICE	3.71	2.63	0.19	6.53	2	000
93640	TC	A	EVALUATION HEART DEVICE	0.00	0.43	0.03	0.46		000
93640	26	A	EVALUATION HEART DEVICE	3.71	2.20	0.16	6.07	2	000
93650		C	ABLATE HEART DYSRHYTHM FOCUS	0.00	0.00	0.00	0.00		000
93650	TC	C	ABLATE HEART DYSRHYTHM FOCUS	0.00	0.00	0.00	0.00		000
93650	26	A	ABLATE HEART DYSRHYTHM FOCUS	7.96	4.71	0.35	13.02	2	000
93660		C	TILT TABLE EVALUATION	0.00	0.00	0.00	0.00		000
93660	TC	C	TILT TABLE EVALUATION	0.00	0.00	0.00	0.00		000
93660	26	A	TILT TABLE EVALUATION	1.06	0.81	0.09	1.96	2	000
93720		A	TOTAL BODY PLETHYSMOGRAPHY	0.18	0.69	0.07	0.94	2	XXX
93721		A	PLETHYSMOGRAPHY TRACING	0.00	0.36	0.04	0.40		XXX
93722		A	PLETHYSMOGRAPHY REPORT	0.18	0.33	0.03	0.54	2	XXX
93731		A	ANALYZE PACEMAKER SYSTEM	0.48	0.75	0.06	1.29	2	XXX
93731	TC	A	ANALYZE PACEMAKER SYSTEM	0.00	0.42	0.03	0.45		XXX
93731	26	A	ANALYZE PACEMAKER SYSTEM	0.48	0.33	0.03	0.84	2	XXX
93732		A	ANALYZE PACEMAKER SYSTEM	0.69	0.90	0.08	1.67	2	XXX
93732	TC	A	ANALYZE PACEMAKER SYSTEM	0.00	0.46	0.04	0.50		XXX
93732	26	A	ANALYZE PACEMAKER SYSTEM	0.69	0.44	0.04	1.17	2	XXX
93733		A	TELEPHONE ANALYSIS, PACEMAKER	0.48	0.78	0.06	1.32	2	XXX
93733	TC	A	TELEPHONE ANALYSIS, PACEMAKER	0.00	0.50	0.04	0.54		XXX
93733	26	A	TELEPHONE ANALYSIS, PACEMAKER	0.48	0.28	0.02	0.78	2	XXX
93734		A	ANALYZE PACEMAKER SYSTEM	0.39	0.65	0.06	1.10	2	XXX
93734	TC	A	ANALYZE PACEMAKER SYSTEM	0.00	0.33	0.03	0.36		XXX
93734	26	A	ANALYZE PACEMAKER SYSTEM	0.39	0.32	0.03	0.74	2	XXX
93735		A	ANALYZE PACEMAKER SYSTEM	0.53	0.85	0.08	1.46	2	XXX
93735	TC	A	ANALYZE PACEMAKER SYSTEM	0.00	0.40	0.04	0.44		XXX
93735	26	A	ANALYZE PACEMAKER SYSTEM	0.53	0.45	0.04	1.02	2	XXX
93736		A	TELEPHONE ANALYSIS, PACEMAKER	0.39	0.75	0.07	1.21	1	XXX
93736	TC	A	TELEPHONE ANALYSIS, PACEMAKER	0.00	0.46	0.04	0.50		XXX
93736	26	A	TELEPHONE ANALYSIS, PACEMAKER	0.39	0.29	0.03	0.71	1	XXX
93737		A	ANALYZE CARDIO/DEFIBRILLATOR	0.47	0.70	0.05	1.22	2	XXX
93737	TC	A	ANALYZE CARDIO/DEFIBRILLATOR	0.00	0.42	0.03	0.45		XXX
93737	26	A	ANALYZE CARDIO/DEFIBRILLATOR	0.47	0.28	0.02	0.77	2	XXX
93738		A	ANALYZE CARDIO/DEFIBRILLATOR	0.69	0.87	0.07	1.63	2	XXX
93738	TC	A	ANALYZE CARDIO/DEFIBRILLATOR	0.00	0.46	0.04	0.50		XXX
93738	26	A	ANALYZE CARDIO/DEFIBRILLATOR	0.69	0.41	0.03	1.13	2	XXX
93740		A	TEMPERATURE GRADIENT STUDIES	0.16	0.47	0.04	0.67	2	XXX
93740	TC	A	TEMPERATURE GRADIENT STUDIES	0.00	0.16	0.01	0.17		XXX
93740	26	A	TEMPERATURE GRADIENT STUDIES	0.16	0.31	0.03	0.50	2	XXX
93760		A	CEPHALIC THERMOGRAM	0.16	1.74	0.17	2.07	2	XXX
93760	TC	A	CEPHALIC THERMOGRAM	0.00	1.18	0.12	1.30		XXX
93760	26	A	CEPHALIC THERMOGRAM	0.16	0.56	0.05	0.77	2	XXX
93762		A	PERIPHERAL THERMOGRAM	0.16	1.30	0.12	1.58	2	XXX
93762	TC	A	PERIPHERAL THERMOGRAM	0.00	0.71	0.07	0.78		XXX
93762	26	A	PERIPHERAL THERMOGRAM	0.16	0.59	0.05	0.80	2	XXX
93770		A	MEASURE VENOUS PRESSURE	0.16	0.19	0.02	0.37	2	XXX
93770	TC	A	MEASURE VENOUS PRESSURE	0.00	0.02	0.00	0.02		XXX
93770	26	A	MEASURE VENOUS PRESSURE	0.16	0.17	0.02	0.35	2	XXX
93784		N	AMBULATORY BP MONITORING	0.00	0.00	0.00	0.00		XXX
93786		N	AMBULATORY BP RECORDING	0.00	0.00	0.00	0.00		XXX
93788		N	AMBULATORY BP ANALYSIS	0.00	0.00	0.00	0.00		XXX
93790		N	REVIEW/REPORT BP RECORDING	0.00	0.00	0.00	0.00		XXX
93797		A	CARDIAC REHAB	0.19	0.31	0.02	0.52	2	000
93798		A	CARDIAC REHAB/MONITOR	0.29	0.50	0.04	0.83	2	000
93799		C	CARDIOVASCULAR PROCEDURE	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
93850		D	CEREBRAL ARTERY STUDY	0.00	0.00	0.00	0.00		XXX
93860		D	CAROTID ARTERY STUDY	0.00	0.00	0.00	0.00		XXX
93870		D	CAROTID ARTERY IMAGING	0.00	0.00	0.00	0.00		XXX
93875		A	EXTRACRANIAL STUDY	0.23	1.63	0.17	2.03	2	XXX
93875	TC	A	EXTRACRANIAL STUDY	0.00	1.05	0.11	1.16		XXX
93875	26	A	EXTRACRANIAL STUDY	0.23	0.58	0.06	0.87	2	XXX
93880		A	EXTRACRANIAL STUDY	0.64	3.71	0.42	4.77	2	XXX
93880	TC	A	EXTRACRANIAL STUDY	0.00	3.23	0.37	3.60		XXX
93880	26	A	EXTRACRANIAL STUDY	0.64	0.48	0.05	1.17	2	XXX
93882		A	EXTRACRANIAL STUDY	0.31	3.47	0.40	4.18	2	XXX
93882	TC	A	EXTRACRANIAL STUDY	0.00	3.23	0.37	3.60		XXX
93882	26	A	EXTRACRANIAL STUDY	0.31	0.24	0.03	0.58	2	XXX
93886		A	INTRACRANIAL STUDY	0.96	3.95	0.45	5.36	2	XXX
93886	TC	A	INTRACRANIAL STUDY	0.00	3.23	0.37	3.60		XXX
93886	26	A	INTRACRANIAL STUDY	0.96	0.72	0.08	1.76	2	XXX
93888		A	INTRACRANIAL STUDY	0.47	3.59	0.41	4.47	2	XXX
93888	TC	A	INTRACRANIAL STUDY	0.00	3.23	0.37	3.60		XXX
93888	26	A	INTRACRANIAL STUDY	0.47	0.36	0.04	0.87	2	XXX
93890		D	UPPER LIMB ARTERY STUDY	0.00	0.00	0.00	0.00		XXX
93910		D	LOWER LIMB ARTERY STUDY	0.00	0.00	0.00	0.00		XXX
93920		A	UPPER EXTREMITY STUDY	0.32	3.06	0.32	3.70	2	XXX
93920	TC	A	UPPER EXTREMITY STUDY	0.00	2.38	0.25	2.63		XXX
93920	26	A	UPPER EXTREMITY STUDY	0.32	0.68	0.07	1.07	2	XXX
93921		A	LOWER EXTREMITY STUDY	0.42	2.43	0.31	3.16	2	XXX
93921	TC	A	LOWER EXTREMITY STUDY	0.00	1.75	0.22	1.97		XXX
93921	26	A	LOWER EXTREMITY STUDY	0.42	0.68	0.09	1.19	2	XXX
93925		A	LOWER EXTREMITY STUDY	0.64	3.71	0.42	4.77	2	XXX
93925	TC	A	LOWER EXTREMITY STUDY	0.00	3.23	0.37	3.60		XXX
93925	26	A	LOWER EXTREMITY STUDY	0.64	0.48	0.05	1.17	2	XXX
93926		A	LOWER EXTREMITY STUDY	0.31	3.47	0.40	4.18	2	XXX
93926	TC	A	LOWER EXTREMITY STUDY	0.00	3.23	0.37	3.60		XXX
93926	26	A	LOWER EXTREMITY STUDY	0.31	0.24	0.03	0.58	2	XXX
93930		A	UPPER EXTREMITY STUDY	0.54	3.63	0.41	4.58	2	XXX
93930	TC	A	UPPER EXTREMITY STUDY	0.00	3.23	0.37	3.60		XXX
93930	26	A	UPPER EXTREMITY STUDY	0.54	0.40	0.04	0.98	2	XXX
93931		A	UPPER EXTREMITY STUDY	0.26	3.43	0.39	4.08	2	XXX
93931	TC	A	UPPER EXTREMITY STUDY	0.00	3.23	0.37	3.60		XXX
93931	26	A	UPPER EXTREMITY STUDY	0.26	0.20	0.02	0.48	2	XXX
93950		D	LIMB VEIN STUDY	0.00	0.00	0.00	0.00		XXX
93960		D	VENOUS FLOW STUDY, CALF	0.00	0.00	0.00	0.00		XXX
93965		A	EXTREMITY STUDY	0.36	1.32	0.16	1.84	2	XXX
93965	TC	A	EXTREMITY STUDY	0.00	0.82	0.10	0.92		XXX
93965	26	A	EXTREMITY STUDY	0.36	0.50	0.06	0.92	2	XXX
93970		A	EXTREMITY STUDY	0.74	3.80	0.44	4.98	2	XXX
93970	TC	A	EXTREMITY STUDY	0.00	3.23	0.37	3.60		XXX
93970	26	A	EXTREMITY STUDY	0.74	0.57	0.07	1.38	2	XXX
93971		A	EXTREMITY STUDY	0.37	3.51	0.40	4.28	2	XXX
93971	TC	A	EXTREMITY STUDY	0.00	3.23	0.37	3.60		XXX
93971	26	A	EXTREMITY STUDY	0.37	0.23	0.03	0.68	2	XXX
93975		A	VISCERAL VASCULAR STUDY	1.06	4.04	0.46	5.56	2	XXX
93975	TC	A	VISCERAL VASCULAR STUDY	0.00	3.23	0.37	3.60		XXX
93975	26	A	VISCERAL VASCULAR STUDY	1.06	0.81	0.09	1.96	2	XXX
93976		A	VISCERAL VASCULAR STUDY	0.54	3.63	0.41	4.58	2	XXX
93976	TC	A	VISCERAL VASCULAR STUDY	0.00	3.23	0.37	3.60		XXX
93976	26	A	VISCERAL VASCULAR STUDY	0.54	0.40	0.04	0.98	2	XXX
93978		A	VISCERAL VASCULAR STUDY	0.71	3.77	0.43	4.91	2	XXX
93978	TC	A	VISCERAL VASCULAR STUDY	0.00	3.23	0.37	3.60		XXX
93978	26	A	VISCERAL VASCULAR STUDY	0.71	0.54	0.06	1.31	2	XXX
93979		A	VISCERAL VASCULAR STUDY	0.36	3.50	0.40	4.26	2	XXX
93979	TC	A	VISCERAL VASCULAR STUDY	0.00	3.23	0.37	3.60		XXX
93979	26	A	VISCERAL VASCULAR STUDY	0.36	0.27	0.03	0.66	2	XXX
94010		A	BREATHING CAPACITY TEST	0.17	0.71	0.05	0.93	1	XXX
94010	TC	A	BREATHING CAPACITY TEST	0.00	0.42	0.03	0.45		XXX
94010	26	A	BREATHING CAPACITY TEST	0.17	0.29	0.02	0.48	1	XXX
94060		A	EVALUATION OF WHEEZING	0.32	1.28	0.09	1.69	2	XXX
94060	TC	A	EVALUATION OF WHEEZING	0.00	0.89	0.06	0.95		XXX
94060	26	A	EVALUATION OF WHEEZING	0.32	0.39	0.03	0.74	2	XXX
94070		A	EVALUATION OF WHEEZING	0.64	1.51	0.11	2.26	2	XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
94070	TC	A	EVALUATION OF WHEEZING	0.00	1.12	0.08	1.20		XXX
94070	26	A	EVALUATION OF WHEEZING	0.64	0.39	0.03	1.06	2	XXX
94150		A	VITAL CAPACITY TEST	0.11	0.20	0.02	0.33	2	XXX
94150	TC	A	VITAL CAPACITY TEST	0.00	0.08	0.01	0.09		XXX
94150	26	A	VITAL CAPACITY TEST	0.11	0.12	0.01	0.24	2	XXX
94160		A	VITAL CAPACITY SCREENING	0.19	0.34	0.02	0.55	2	XXX
94160	TC	A	VITAL CAPACITY SCREENING	0.00	0.14	0.01	0.15		XXX
94160	26	A	VITAL CAPACITY SCREENING	0.19	0.20	0.01	0.40	2	XXX
94200		A	LUNG FUNCTION TEST (MBC/MVV)	0.11	0.40	0.03	0.54	2	XXX
94200	TC	A	LUNG FUNCTION TEST (MBC/MVV)	0.00	0.21	0.02	0.23		XXX
94200	26	A	LUNG FUNCTION TEST (MBC/MVV)	0.11	0.19	0.01	0.31	2	XXX
94240		A	RESIDUAL LUNG CAPACITY	0.27	0.71	0.05	1.03	2	XXX
94240	TC	A	RESIDUAL LUNG CAPACITY	0.00	0.47	0.03	0.50		XXX
94240	26	A	RESIDUAL LUNG CAPACITY	0.27	0.24	0.02	0.53	2	XXX
94250		A	EXPIRED GAS COLLECTION	0.11	0.24	0.02	0.37	2	XXX
94250	TC	A	EXPIRED GAS COLLECTION	0.00	0.09	0.01	0.10		XXX
94250	26	A	EXPIRED GAS COLLECTION	0.11	0.15	0.01	0.27	2	XXX
94260		A	THORACIC GAS VOLUME	0.13	0.57	0.04	0.74	2	XXX
94260	TC	A	THORACIC GAS VOLUME	0.00	0.30	0.02	0.32		XXX
94260	26	A	THORACIC GAS VOLUME	0.13	0.27	0.02	0.42	2	XXX
94350		A	LUNG NITROGEN WASHOUT CURVE	0.27	0.52	0.03	0.82	2	XXX
94350	TC	A	LUNG NITROGEN WASHOUT CURVE	0.00	0.30	0.02	0.32		XXX
94350	26	A	LUNG NITROGEN WASHOUT CURVE	0.27	0.22	0.01	0.50	2	XXX
94360		A	MEASURE AIRFLOW RESISTANCE	0.27	0.49	0.03	0.79	2	XXX
94360	TC	A	MEASURE AIRFLOW RESISTANCE	0.00	0.29	0.02	0.31		XXX
94360	26	A	MEASURE AIRFLOW RESISTANCE	0.27	0.20	0.01	0.48	2	XXX
94370		A	BREATH AIRWAY CLOSING VOLUME	0.27	0.29	0.02	0.58	2	XXX
94370	TC	A	BREATH AIRWAY CLOSING VOLUME	0.00	0.15	0.01	0.16		XXX
94370	26	A	BREATH AIRWAY CLOSING VOLUME	0.27	0.14	0.01	0.42	2	XXX
94375		A	RESPIRATORY FLOW VOLUME LOOP	0.32	0.65	0.04	1.01	2	XXX
94375	TC	A	RESPIRATORY FLOW VOLUME LOOP	0.00	0.43	0.03	0.46		XXX
94375	26	A	RESPIRATORY FLOW VOLUME LOOP	0.32	0.22	0.01	0.55	2	XXX
94400		A	CO2 BREATHING RESPONSE CURVE	0.42	0.73	0.15	1.30	2	XXX
94400	TC	A	CO2 BREATHING RESPONSE CURVE	0.00	0.23	0.02	0.25		XXX
94400	26	A	CO2 BREATHING RESPONSE CURVE	0.42	0.50	0.13	1.05	2	XXX
94450		A	HYPOXIA RESPONSE CURVE	0.42	0.48	0.04	0.94	2	XXX
94450	TC	A	HYPOXIA RESPONSE CURVE	0.00	0.23	0.02	0.25		XXX
94450	26	A	HYPOXIA RESPONSE CURVE	0.42	0.25	0.02	0.69	2	XXX
94620		A	PULMONARY STRESS TESTING	0.93	2.05	0.14	3.12	2	XXX
94620	TC	A	PULMONARY STRESS TESTING	0.00	1.31	0.09	1.40		XXX
94620	26	A	PULMONARY STRESS TESTING	0.93	0.74	0.05	1.72	2	XXX
94640		A	AIRWAY INHALATION TREATMENT	0.00	0.41	0.03	0.44		XXX
94642	C	A	AEROSOL INHALATION TREATMENT	0.00	0.00	0.00	0.00		XXX
94650		A	PRESSURE BREATHING (IPPB)	0.00	0.38	0.03	0.41		XXX
94651		A	PRESSURE BREATHING (IPPB)	0.00	0.37	0.03	0.40		XXX
94652		A	PRESSURE BREATHING (IPPB)	0.00	0.43	0.08	0.51		XXX
94656		A	INITIAL VENTILATOR MANAGEMENT	1.29	1.18	0.12	2.59	1	000
94657		A	CONT. VENTILATOR MANAGEMENT	0.87	0.66	0.05	1.58	1	000
94660		A	POS AIRWAY PRESSURE, CPAP	0.80	0.75	0.06	1.61	2	000
94662		A	NEG PRESSURE VENTILATION, CNP	0.80	0.31	0.02	1.13	2	000
94664		A	AEROSOL OR VAPOR INHALATIONS	0.00	0.54	0.04	0.58		XXX
94665		A	AEROSOL OR VAPOR INHALATIONS	0.00	0.49	0.05	0.54		XXX
94667		A	CHEST WALL MANIPULATION	0.00	0.59	0.05	0.64		XXX
94668		A	CHEST WALL MANIPULATION	0.00	0.35	0.03	0.38		XXX
94680		A	EXHALED AIR ANALYSIS: O2	0.27	0.54	0.05	0.86	2	XXX
94680	TC	A	EXHALED AIR ANALYSIS: O2	0.00	0.20	0.02	0.22		XXX
94680	26	A	EXHALED AIR ANALYSIS: O2	0.27	0.34	0.03	0.64	2	XXX
94681		A	EXHALED AIR ANALYSIS: O2, CO2	0.21	1.23	0.09	1.53	2	XXX
94681	TC	A	EXHALED AIR ANALYSIS: O2, CO2	0.00	0.75	0.05	0.80		XXX
94681	26	A	EXHALED AIR ANALYSIS: O2, CO2	0.21	0.48	0.04	0.73	2	XXX
94690		A	EXHALED AIR ANALYSIS	0.07	0.19	0.02	0.28	2	XXX
94690	TC	A	EXHALED AIR ANALYSIS	0.00	0.14	0.02	0.16		XXX
94690	26	A	EXHALED AIR ANALYSIS	0.07	0.05	0.00	0.12	2	XXX
94700		B	BLOOD GAS ANALYSIS	0.00	0.00	0.00	0.00		XXX
94705		A	ARTERIAL BLOOD GAS ANALYSES	1.21	0.30	0.02	1.53	2	XXX
94710		B	ARTERIAL BLOOD GAS ANALYSES	0.00	0.00	0.00	0.00		XXX
94715		A	HEMOGLOBIN-OXYGEN AFFINITY	0.21	0.36	0.06	0.63	2	XXX
94715	TC	A	HEMOGLOBIN-OXYGEN AFFINITY	0.00	0.13	0.02	0.15		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
94715	26	A	HEMOGLOBIN-OXYGEN AFFINITY	0.21	0.23	0.04	0.48	2	XXX
94720		A	MONOXIDE DIFFUSING CAPACITY	0.27	1.00	0.07	1.34	2	XXX
94720	TC	A	MONOXIDE DIFFUSING CAPACITY	0.00	0.76	0.05	0.81		XXX
94720	26	A	MONOXIDE DIFFUSING CAPACITY	0.27	0.24	0.02	0.53	2	XXX
94725		A	MEMBRANE DIFFUSION CAPACITY	0.27	0.70	0.06	1.03	2	XXX
94725	TC	A	MEMBRANE DIFFUSION CAPACITY	0.00	0.51	0.05	0.56		XXX
94725	26	A	MEMBRANE DIFFUSION CAPACITY	0.27	0.19	0.01	0.47	2	XXX
94750		A	PULMONARY COMPLIANCE STUDY	0.24	0.60	0.05	0.89	2	XXX
94750	TC	A	PULMONARY COMPLIANCE STUDY	0.00	0.31	0.03	0.34		XXX
94750	26	A	PULMONARY COMPLIANCE STUDY	0.24	0.29	0.02	0.55	2	XXX
94760		A	MEASURE BLOOD OXYGEN LEVEL	0.00	0.26	0.02	0.28		XXX
94761		A	MEASURE BLOOD OXYGEN LEVEL	0.00	0.68	0.06	0.74		XXX
94762		A	MEASURE BLOOD OXYGEN LEVEL	0.00	1.13	0.10	1.23		XXX
94770		A	EXHALED CARBON DIOXIDE TEST	0.21	0.33	0.08	0.62	2	XXX
94770	TC	A	EXHALED CARBON DIOXIDE TEST	0.00	0.22	0.05	0.27		XXX
94770	26	A	EXHALED CARBON DIOXIDE TEST	0.21	0.11	0.03	0.35	2	XXX
94772		C	BREATH RECORDING, INFANT	0.00	0.00	0.00	0.00		XXX
94772	TC	C	BREATH RECORDING, INFANT	0.00	0.00	0.00	0.00		XXX
94772	26	C	BREATH RECORDING, INFANT	0.00	0.00	0.00	0.00		XXX
94799		C	PULMONARY SERVICE/PROCEDURE	0.00	0.00	0.00	0.00		XXX
95000		A	ALLERGY SKIN TESTS, 1-30	0.00	0.09	0.01	0.10		XXX
95001		A	ALLERGY SKIN TESTS, 31-60	0.00	0.09	0.01	0.10		XXX
95002		A	ALLERGY SKIN TESTS, 61-90	0.00	0.09	0.01	0.10		XXX
95003		A	ALLERGY SKIN TESTS, OVER 90	0.00	0.09	0.01	0.10		XXX
95005		A	SENSITIVITY SKIN TESTS, 1-5	0.00	0.21	0.01	0.22		XXX
95006		A	SENSITIVITY SKIN TESTS, 6-10	0.00	0.21	0.01	0.22		XXX
95007		A	SENSITIVITY SKIN TESTS, 11-15	0.00	0.21	0.01	0.22		XXX
95011		A	SENSITIVITY SKIN TESTS, 15+	0.00	0.21	0.01	0.22		XXX
95014		A	SENSITIVITY SKIN TESTS, 1-5	0.00	0.22	0.01	0.23		XXX
95016		A	SENSITIVITY SKIN TESTS, 6-10	0.00	0.22	0.01	0.23		XXX
95017		A	SENSITIVITY SKIN TESTS, 11-15	0.00	0.22	0.01	0.23		XXX
95018		A	SENSITIVITY SKIN TESTS, 15+	0.00	0.22	0.01	0.23		XXX
95020		A	ALLERGY SKIN TESTS, 1-10	0.00	0.14	0.01	0.15		XXX
95021		A	ALLERGY SKIN TESTS, 11-20	0.00	0.14	0.01	0.15		XXX
95022		A	ALLERGY SKIN TESTS, 21-30	0.00	0.14	0.01	0.15		XXX
95023		A	ALLERGY SKIN TESTS, OVER 30	0.00	0.14	0.01	0.15		XXX
95027		A	SKIN END POINT TITRATION	0.00	0.14	0.01	0.15		XXX
95030		A	ALLERGY SKIN TESTS, 2	0.00	0.23	0.01	0.24		XXX
95031		A	ALLERGY SKIN TESTS, 3-4	0.00	0.23	0.01	0.24		XXX
95032		A	ALLERGY SKIN TESTS, 5-6	0.00	0.23	0.01	0.24		XXX
95033		A	ALLERGY SKIN TESTS, 7-8	0.00	0.23	0.01	0.24		XXX
95034		A	ALLERGY SKIN TESTS, OVER 8	0.00	0.23	0.01	0.24		XXX
95040		A	ALLERGY PATCH TESTS, 1-10	0.00	0.20	0.01	0.21		XXX
95041		A	ALLERGY PATCH TESTS, 11-20	0.00	0.20	0.01	0.21		XXX
95042		A	ALLERGY PATCH TESTS, 21-30	0.00	0.20	0.01	0.21		XXX
95043		A	ALLERGY PATCH TESTS, OVER 30	0.00	0.20	0.01	0.21		XXX
95050		A	PHOTO PATCH TESTS, 1-10	0.00	0.47	0.03	0.50		XXX
95051		A	PHOTO PATCH TESTS, OVER 10	0.00	0.13	0.01	0.14		XXX
95056		A	PHOTOSENSITIVITY TESTS	0.00	0.17	0.01	0.18		XXX
95060		A	EYE ALLERGY TESTS	0.00	0.34	0.02	0.36		XXX
95065		A	NOSE ALLERGY TEST	0.00	0.20	0.01	0.21		XXX
95070		A	BRONCHIAL ALLERGY TESTS	0.00	2.28	0.02	2.30		XXX
95071		A	BRONCHIAL ALLERGY TESTS	0.00	2.93	0.02	2.95		XXX
95075		A	INGESTION CHALLENGE TEST	0.00	2.08	0.02	2.10		XXX
95078		A	PROVOCATIVE TESTING	0.00	0.25	0.02	0.27		XXX
95080		D	PASSIVE TRANSFER TESTS, 1-10	0.00	0.00	0.00	0.00		XXX
95081		D	PASSIVE TRANSFER TESTS, 11-20	0.00	0.00	0.00	0.00		XXX
95082		D	PASSIVE TRANSFER TESTS, 20+	0.00	0.00	0.00	0.00		XXX
95105		A	ALLERGY PATIENT COUNSELING	0.38	0.38	0.03	0.79	2	XXX
95115		A	IMMUNOTHERAPY, ONE INJECTION	0.00	0.45	0.02	0.47		XXX
95117		A	IMMUNOTHERAPY INJECTIONS	0.00	0.71	0.02	0.73		XXX
95120		X	IMMUNOTHERAPY, ONE ANTIGEN	0.00	0.00	0.00	0.00		XXX
95125		X	IMMUNOTHERAPY, MANY ANTIGENS	0.00	0.00	0.00	0.00		XXX
95130		X	IMMUNOTHERAPY, INSECT VENOM	0.00	0.00	0.00	0.00		XXX
95131		X	IMMUNOTHERAPY, INSECT VENOMS	0.00	0.00	0.00	0.00		XXX
95132		X	IMMUNOTHERAPY, INSECT VENOMS	0.00	0.00	0.00	0.00		XXX
95133		X	IMMUNOTHERAPY, INSECT VENOMS	0.00	0.00	0.00	0.00		XXX
95134		X	IMMUNOTHERAPY, INSECT VENOMS	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
95135		X	IMMUNOTHERAPY, ONE ANTIGEN	0.00	0.00	0.00	0.00		XXX
95140		X	IMMUNOTHERAPY, MANY ANTIGENS	0.00	0.00	0.00	0.00		XXX
95145		X	ANTIGEN THERAPY SERVICES	0.00	0.00	0.00	0.00		XXX
95146		X	ANTIGEN THERAPY SERVICES	0.00	0.00	0.00	0.00		XXX
95147		X	ANTIGEN THERAPY SERVICES	0.00	0.00	0.00	0.00		XXX
95148		X	ANTIGEN THERAPY SERVICES	0.00	0.00	0.00	0.00		XXX
95149		X	ANTIGEN THERAPY SERVICES	0.00	0.00	0.00	0.00		XXX
95150		X	ANTIGEN THERAPY SERVICES	0.00	0.00	0.00	0.00		XXX
95155		X	ANTIGEN THERAPY SERVICES	0.00	0.00	0.00	0.00		XXX
95170		X	ANTIGEN THERAPY SERVICES	0.00	0.00	0.00	0.00		XXX
95180		A	RAPID DESENSITIZATION	2.12	0.14	0.01	2.27	2	XXX
95199		C	ALLERGY IMMUNOLOGY SERVICES	0.00	0.00	0.00	0.00		XXX
95805		A	MULTIPLE SLEEP LATENCY TEST	0.80	2.23	0.19	3.22	2	XXX
95805	TC	A	MULTIPLE SLEEP LATENCY TEST	0.00	1.63	0.12	1.75		XXX
95805	26	A	MULTIPLE SLEEP LATENCY TEST	0.80	0.60	0.07	1.47	2	XXX
95816		A	ELECTROENCEPHALOGRAPH (EEG)	0.39	1.49	0.13	2.01	2	XXX
95816	TC	A	ELECTROENCEPHALOGRAPH (EEG)	0.00	1.20	0.10	1.30		XXX
95816	26	A	ELECTROENCEPHALOGRAPH (EEG)	0.39	0.29	0.03	0.71	2	XXX
95817		A	ELECTROENCEPHALOGRAPH (EEG)	0.39	0.80	0.07	1.26	2	XXX
95817	TC	A	ELECTROENCEPHALOGRAPH (EEG)	0.00	0.51	0.04	0.55		XXX
95817	26	A	ELECTROENCEPHALOGRAPH (EEG)	0.39	0.29	0.03	0.71	2	XXX
95819		A	ELECTROENCEPHALOGRAPH (EEG)	0.39	1.73	0.14	2.26	1	XXX
95819	TC	A	ELECTROENCEPHALOGRAPH (EEG)	0.00	1.20	0.10	1.30		XXX
95819	26	A	ELECTROENCEPHALOGRAPH (EEG)	0.39	0.53	0.04	0.96	1	XXX
95821		A	PORTABLE EEG	0.39	1.12	0.08	1.59	2	XXX
95821	TC	A	PORTABLE EEG	0.00	0.51	0.04	0.55		XXX
95821	26	A	PORTABLE EEG	0.39	0.61	0.04	1.04	2	XXX
95822		A	SLEEP ELECTROENCEPHALOGRAPH	0.45	1.64	0.12	2.21	1	XXX
95822	TC	A	SLEEP ELECTROENCEPHALOGRAPH	0.00	1.04	0.08	1.12		XXX
95822	26	A	SLEEP ELECTROENCEPHALOGRAPH	0.45	0.60	0.04	1.09	1	XXX
95823		A	ACTIVATION EEG	0.45	2.37	0.18	3.00	1	XXX
95823	TC	A	ACTIVATION EEG	0.00	1.70	0.13	1.83		XXX
95823	26	A	ACTIVATION EEG	0.45	0.67	0.05	1.17	1	XXX
95824		A	ELECTROENCEPHALOGRAPHY	0.27	0.89	0.06	1.22	1	XXX
95824	TC	A	ELECTROENCEPHALOGRAPHY	0.00	0.27	0.02	0.29		XXX
95824	26	A	ELECTROENCEPHALOGRAPHY	0.27	0.62	0.04	0.93	1	XXX
95826		A	DEPTH ELECTROENCEPHALOGRAPH	0.44	1.12	0.08	1.64	1	XXX
95826	TC	A	DEPTH ELECTROENCEPHALOGRAPH	0.00	0.41	0.03	0.44		XXX
95826	26	A	DEPTH ELECTROENCEPHALOGRAPH	0.44	0.71	0.05	1.20	1	XXX
95827		A	NIGHT ELECTROENCEPHALOGRAPH	0.67	2.17	0.17	3.01	1	XXX
95827	TC	A	NIGHT ELECTROENCEPHALOGRAPH	0.00	1.24	0.10	1.34		XXX
95827	26	A	NIGHT ELECTROENCEPHALOGRAPH	0.67	0.93	0.07	1.67	1	XXX
95828		A	POLYSOMNOGRAPHY	1.35	3.54	0.26	5.15	1	XXX
95828	TC	A	POLYSOMNOGRAPHY	0.00	1.63	0.12	1.75		XXX
95828	26	A	POLYSOMNOGRAPHY	1.35	1.91	0.14	3.40	1	XXX
95829		A	SURGERY ELECTROCORITCOGRAM	1.00	1.04	0.12	2.16	1	XXX
95829	TC	A	SURGERY ELECTROCORITCOGRAM	0.00	0.57	0.09	0.66		XXX
95829	26	A	SURGERY ELECTROCORITCOGRAM	1.00	0.47	0.03	1.50	1	XXX
95830		A	INSERT ELECTRODES FOR EEG	0.89	0.82	0.07	1.78	2	XXX
95831		A	LIMB MUSCLE TESTING, MANUAL	0.29	0.30	0.03	0.62	1	XXX
95832		A	HAND MUSCLE TESTING, MANUAL	0.30	0.26	0.02	0.58	1	XXX
95833		A	BODY MUSCLE TESTING, MANUAL	0.50	0.40	0.05	0.95	1	XXX
95834		A	BODY MUSCLE TESTING, MANUAL	0.64	0.65	0.06	1.35	2	XXX
95842		A	MUSCLE TESTING, ELECTRICAL	0.58	0.65	0.06	1.29	1	XXX
95842	TC	A	MUSCLE TESTING, ELECTRICAL	0.00	0.21	0.02	0.23		XXX
95842	26	A	MUSCLE TESTING, ELECTRICAL	0.58	0.44	0.04	1.06	1	XXX
95851		A	RANGE OF MOTION MEASUREMENTS	0.29	0.25	0.02	0.56	1	XXX
95852		A	RANGE OF MOTION MEASUREMENTS	0.20	0.15	0.02	0.37	1	XXX
95857		A	TENSILON TEST	0.57	0.53	0.04	1.14	1	XXX
95858		A	TENSILON TEST & MYOGRAM	1.65	1.02	0.08	2.75	1	XXX
95858	TC	A	TENSILON TEST & MYOGRAM	0.00	0.34	0.03	0.37		XXX
95858	26	A	TENSILON TEST & MYOGRAM	1.65	0.68	0.05	2.38	1	XXX
95860		A	MUSCLE TEST, ONE LIMB	1.01	1.22	0.10	2.33	1	XXX
95860	TC	A	MUSCLE TEST, ONE LIMB	0.00	0.45	0.04	0.49		XXX
95860	26	A	MUSCLE TEST, ONE LIMB	1.01	0.77	0.06	1.84	1	XXX
95861		A	MUSCLE TEST, TWO LIMBS	1.63	2.28	0.17	4.08	1	XXX
95861	TC	A	MUSCLE TEST, TWO LIMBS	0.00	0.94	0.07	1.01		XXX
95861	26	A	MUSCLE TEST, TWO LIMBS	1.63	1.34	0.10	3.07	1	XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
95863		A	MUSCLE TEST, THREE LIMBS	1.96	2.49	0.19	4.64	1	XXX
95863	TC	A	MUSCLE TEST, THREE LIMBS	0.00	1.00	0.08	1.08		XXX
95863	26	A	MUSCLE TEST, THREE LIMBS	1.96	1.49	0.11	3.56	1	XXX
95864		A	MUSCLE TEST, FOUR LIMBS	2.10	3.31	0.25	5.66	1	XXX
95864	TC	A	MUSCLE TEST, FOUR LIMBS	0.00	1.47	0.11	1.58		XXX
95864	26	A	MUSCLE TEST, FOUR LIMBS	2.10	1.84	0.14	4.08	1	XXX
95867		A	MUSCLE TEST, HEAD OR NECK	0.66	1.00	0.08	1.74	1	XXX
95867	TC	A	MUSCLE TEST, HEAD OR NECK	0.00	0.38	0.03	0.41		XXX
95867	26	A	MUSCLE TEST, HEAD OR NECK	0.66	0.62	0.05	1.33	1	XXX
95868		A	MUSCLE TEST, HEAD OR NECK	1.58	1.97	0.15	3.70	1	XXX
95868	TC	A	MUSCLE TEST, HEAD OR NECK	0.00	0.64	0.05	0.69		XXX
95868	26	A	MUSCLE TEST, HEAD OR NECK	1.58	1.33	0.10	3.01	1	XXX
95869		A	MUSCLE TEST, LIMITED	0.38	0.60	0.05	1.03	1	XXX
95869	TC	A	MUSCLE TEST, LIMITED	0.00	0.26	0.02	0.28		XXX
95869	26	A	MUSCLE TEST, LIMITED	0.38	0.34	0.03	0.75	1	XXX
95872		A	MUSCLE TEST, ONE FIBER	1.58	1.20	0.11	2.89	1	XXX
95872	TC	A	MUSCLE TEST, ONE FIBER	0.00	0.48	0.05	0.53		XXX
95872	26	A	MUSCLE TEST, ONE FIBER	1.58	0.72	0.06	2.36	1	XXX
95875		A	LIMB EXERCISE TEST	1.41	0.45	0.06	1.92	1	XXX
95875	TC	A	LIMB EXERCISE TEST	0.00	0.22	0.02	0.24		XXX
95875	26	A	LIMB EXERCISE TEST	1.41	0.23	0.04	1.68	1	XXX
95880		B	CEREBRAL APHASIA TESTING	0.00	0.00	0.00	0.00		XXX
95881		B	CEREBRAL DEVELOPMENTAL TEST	0.00	0.00	0.00	0.00		XXX
95882		B	COGNITIVE FUNCTION TESTING	0.00	0.00	0.00	0.00		XXX
95900		A	MOTOR NERVE CONDUCTION TEST	0.44	0.67	0.05	1.16	1	XXX
95900	TC	A	MOTOR NERVE CONDUCTION TEST	0.00	0.31	0.02	0.33		XXX
95900	26	A	MOTOR NERVE CONDUCTION TEST	0.44	0.36	0.03	0.83	1	XXX
95904		A	SENSE NERVE CONDUCTION TEST	0.35	0.63	0.05	1.03	1	XXX
95904	TC	A	SENSE NERVE CONDUCTION TEST	0.00	0.28	0.02	0.30		XXX
95904	26	A	SENSE NERVE CONDUCTION TEST	0.35	0.35	0.03	0.73	1	XXX
95920		A	INTRAOPERATIVE NERVE TESTING	2.12	2.82	0.20	5.14	2	XXX
95920	TC	A	INTRAOPERATIVE NERVE TESTING	0.00	1.31	0.08	1.39		XXX
95920	26	A	INTRAOPERATIVE NERVE TESTING	2.12	1.51	0.12	3.75	2	XXX
95925		A	SOMATOSENSORY TESTING	0.53	2.10	0.16	2.79	2	XXX
95925	TC	A	SOMATOSENSORY TESTING	0.00	1.09	0.08	1.17		XXX
95925	26	A	SOMATOSENSORY TESTING	0.53	1.01	0.08	1.62	2	XXX
95933		A	BLINK REFLEX TEST	0.63	1.13	0.09	1.85	2	XXX
95933	TC	A	BLINK REFLEX TEST	0.00	0.60	0.05	0.65		XXX
95933	26	A	BLINK REFLEX TEST	0.63	0.53	0.04	1.20	2	XXX
95935		A	"H" OR "F" REFLEX STUDY	0.63	0.65	0.05	1.33	1	XXX
95935	TC	A	"H" OR "F" REFLEX STUDY	0.00	0.30	0.02	0.32		XXX
95935	26	A	"H" OR "F" REFLEX STUDY	0.63	0.35	0.03	1.01	1	XXX
95937		A	NEUROMUSCULAR JUNCTION TEST	0.64	0.79	0.07	1.50	2	XXX
95937	TC	A	NEUROMUSCULAR JUNCTION TEST	0.00	0.32	0.03	0.35		XXX
95937	26	A	NEUROMUSCULAR JUNCTION TEST	0.64	0.47	0.04	1.15	2	XXX
95950		A	AMBULATORY EEG MONITORING	1.59	3.03	0.25	4.87	2	XXX
95950	TC	A	AMBULATORY EEG MONITORING	0.00	1.75	0.15	1.90		XXX
95950	26	A	AMBULATORY EEG MONITORING	1.59	1.28	0.10	2.97	2	XXX
95951		A	EEG MONITORING/VIDEORECORD	1.91	3.96	0.29	6.16	2	XXX
95951	TC	A	EEG MONITORING/VIDEORECORD	0.00	2.38	0.18	2.56		XXX
95951	26	A	EEG MONITORING/VIDEORECORD	1.91	1.58	0.11	3.60	2	XXX
95952		A	EEG MONITORING BEYOND 24 HRS	1.59	3.21	0.25	5.05	2	XXX
95952	TC	A	EEG MONITORING BEYOND 24 HRS	0.00	0.95	0.07	1.02		XXX
95952	26	A	EEG MONITORING BEYOND 24 HRS	1.59	2.26	0.18	4.03	2	XXX
95954		A	EEG MONITORING/GIVING DRUGS	0.96	0.75	0.08	1.79	2	XXX
95954	TC	A	EEG MONITORING/GIVING DRUGS	0.00	0.16	0.01	0.17		XXX
95954	26	A	EEG MONITORING/GIVING DRUGS	0.96	0.59	0.07	1.62	2	XXX
95955		A	EEG DURING SURGERY	1.06	1.55	0.15	2.76	2	XXX
95955	TC	A	EEG DURING SURGERY	0.00	0.47	0.04	0.51		XXX
95955	26	A	EEG DURING SURGERY	1.06	1.08	0.11	2.25	2	XXX
95958		A	EEG MONITORING/FUNCTION TEST	2.12	7.62	0.57	10.31	2	XXX
95958	TC	A	EEG MONITORING/FUNCTION TEST	0.00	4.64	0.30	4.94		XXX
95958	26	A	EEG MONITORING/FUNCTION TEST	2.12	2.98	0.27	5.37	2	XXX
95961		A	ELECTRODE STIMULATION, BRAIN	2.12	2.82	0.20	5.14	2	XXX
95961	TC	A	ELECTRODE STIMULATION, BRAIN	0.00	1.31	0.08	1.39		XXX
95961	26	A	ELECTRODE STIMULATION, BRAIN	2.12	1.51	0.12	3.75	2	XXX
95962		A	ELECTRODE STIMULATION, BRAIN	2.12	2.82	0.20	5.14	2	XXX
95962	TC	A	ELECTRODE STIMULATION, BRAIN	0.00	1.31	0.08	1.39		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
95962	26	A	ELECTRODE STIMULATION, BRAIN	2.12	1.51	0.12	3.75	2	XXX
95999		C	NEUROLOGICAL PROCEDURE	0.00	0.00	0.00	0.00		XXX
96400		A	CHEMOTHERAPY, (SC)/(IM)	0.00	0.13	0.01	0.14		XXX
96408		A	CHEMOTHERAPY, PUSH TECHNIQUE	0.00	0.87	0.06	0.93		XXX
96410		A	CHEMOTHERAPY, INFUSION METHOD	0.00	1.34	0.09	1.43		XXX
96412		A	CHEMOTHERAPY, INFUSION METHOD	0.00	1.15	0.08	1.23		XXX
96414		A	CHEMOTHERAPY, INFUSION METHOD	0.00	1.34	0.09	1.43		XXX
96420		A	CHEMOTHERAPY, PUSH TECHNIQUE	0.00	1.14	0.09	1.23		XXX
96422		A	CHEMOTHERAPY, INFUSION METHOD	0.00	1.03	0.09	1.12		XXX
96423		A	CHEMOTHERAPY, INFUSION METHOD	0.00	0.63	0.06	0.69		XXX
96425		A	CHEMOTHERAPY, INFUSION METHOD	0.00	1.44	0.09	1.53		XXX
96440		A	CHEMOTHERAPY, INTRACAVITARY	1.59	0.85	0.06	2.50	2	000
96445		A	CHEMOTHERAPY, INTRACAVITARY	1.59	1.29	0.12	3.00	2	000
96450		A	CHEMOTHERAPY, INTO CNS	1.27	0.92	0.06	2.25	2	000
96520		A	PUMP REFILLING, MAINTENANCE	0.00	0.90	0.06	0.96		XXX
96530		A	PUMP REFILLING, MAINTENANCE	0.00	1.06	0.07	1.13		XXX
96545		B	PROVIDE CHEMOTHERAPY AGENT	0.00	0.00	0.00	0.00		XXX
96549		C	CHEMOTHERAPY, UNSPECIFIED	0.00	0.00	0.00	0.00		XXX
96900		A	ULTRAVIOLET LIGHT THERAPY	0.00	0.40	0.03	0.43		XXX
96910		A	PHOTOCHEMOTHERAPY WITH UV-B	0.00	0.59	0.04	0.63		XXX
96912		A	PHOTOCHEMOTHERAPY WITH UV-A	0.00	0.67	0.05	0.72		XXX
96913		C	PHOTOCHEMOTHERAPY, UV-A OR B	0.00	0.00	0.00	0.00		XXX
96999		C	DERMATOLOGICAL PROCEDURE	0.00	0.00	0.00	0.00		XXX
97010		A	HOT OR COLD PACKS THERAPY	0.24	0.21	0.02	0.47	3	XXX
97012		A	MECHANICAL TRACTION THERAPY	0.22	0.20	0.02	0.44	3	XXX
97014		A	ELECTRIC STIMULATION THERAPY	0.22	0.20	0.02	0.44	3	XXX
97016		A	VASOPNEUMATIC DEVICE THERAPY	0.26	0.23	0.02	0.51	3	XXX
97018		A	PARAFFIN BATH THERAPY	0.26	0.24	0.03	0.53	3	XXX
97020		A	MICROWAVE THERAPY	0.19	0.19	0.02	0.40	3	XXX
97022		A	WHIRLPOOL THERAPY	0.21	0.20	0.02	0.43	3	XXX
97024		A	DIATHERMY TREATMENT	0.20	0.20	0.02	0.42	3	XXX
97026		A	INFRARED THERAPY	0.22	0.20	0.02	0.44	3	XXX
97028		A	ULTRAVIOLET THERAPY	0.20	0.18	0.01	0.39	3	XXX
97039		A	PHYSICAL THERAPY TREATMENT	0.30	0.25	0.03	0.58	3	XXX
97110		A	THERAPEUTIC EXERCISES 30 MIN	0.28	0.23	0.03	0.54	3	XXX
97112		A	NEUROMUSCULAR REEDUCATION	0.26	0.23	0.02	0.51	3	XXX
97114		A	FUNCTIONAL ACTIVITY THERAPY	0.22	0.19	0.02	0.43	3	XXX
97116		A	GAIT TRAINING THERAPY	0.24	0.19	0.02	0.45	3	XXX
97118		A	MANUAL ELECTRIC STIMULATION	0.26	0.25	0.02	0.53	3	XXX
97120		A	ELECTRIC CURRENT THERAPY	0.27	0.24	0.03	0.54	3	XXX
97122		A	MANUAL TRACTION THERAPY	0.21	0.19	0.02	0.42	3	XXX
97124		A	MASSAGE THERAPY	0.22	0.19	0.02	0.43	3	XXX
97126		A	CONTRAST BATHS THERAPY	0.22	0.18	0.02	0.42	3	XXX
97128		A	ULTRASOUND THERAPY	0.22	0.20	0.02	0.44	3	XXX
97139		A	PHYSICAL MEDICINE PROCEDURE	0.36	0.29	0.03	0.68	3	XXX
97145		A	EXTENDED PHYSIOTHERAPY	0.14	0.12	0.01	0.27	3	XXX
97220		A	HYDROTHERAPY	0.40	0.36	0.04	0.80	3	XXX
97221		A	EXTENDED HYDROTHERAPY	0.13	0.11	0.01	0.25	3	XXX
97240		A	HYDROTHERAPY	0.46	0.39	0.05	0.90	3	XXX
97241		A	EXTENDED HYDROTHERAPY	0.12	0.10	0.01	0.23	3	XXX
97260		A	REGIONAL MANIPULATION	0.20	0.21	0.02	0.43	3	XXX
97261		A	SUPPLEMENTAL MANIPULATIONS	0.12	0.11	0.01	0.24	3	XXX
97500		A	ORTHOTICS TRAINING	0.32	0.28	0.04	0.64	3	XXX
97501		A	SUPPLEMENTAL TRAINING	0.18	0.15	0.02	0.35	3	XXX
97520		A	PROSTHETIC TRAINING	0.38	0.31	0.04	0.73	3	XXX
97521		A	SUPPLEMENTAL TRAINING	0.23	0.18	0.02	0.43	3	XXX
97530		A	KINETIC THERAPY	0.37	0.33	0.04	0.74	3	XXX
97531		A	ADDED KINETIC THERAPY	0.19	0.16	0.02	0.37	3	XXX
97540		A	TRAINING FOR DAILY LIVING	0.46	0.38	0.03	0.87	3	XXX
97541		A	SUPPLEMENTAL TRAINING	0.22	0.16	0.01	0.39	3	XXX
97700		A	TRAINING CHECKOUT	0.41	0.36	0.04	0.81	3	XXX
97701		A	SUPPLEMENTAL CHECKOUT	0.20	0.17	0.02	0.39	3	XXX
97720		A	EXTREMITY TESTING	0.43	0.36	0.04	0.83	3	XXX
97721		A	SUPPLEMENTAL LIMB TESTING	0.24	0.19	0.02	0.45	3	XXX
97752		A	MUSCLE TESTING WITH EXERCISE	0.48	0.54	0.06	1.08	3	XXX
97752	TC	A	MUSCLE TESTING WITH EXERCISE	0.00	0.17	0.02	0.19		XXX
97752	26	A	MUSCLE TESTING WITH EXERCISE	0.48	0.37	0.04	0.89	3	XXX
97799		C	PHYSICAL MEDICINE PROCEDURE	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPs*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
98900		D	CONFERENCE WITH PHYSICIAN	0.00	0.00	0.00	0.00		XXX
98902		D	CONFERENCE WITH PHYSICIAN	0.00	0.00	0.00	0.00		XXX
98910		D	CONFERENCE WITH PHYSICIAN	0.00	0.00	0.00	0.00		XXX
98912		D	CONFERENCE WITH PHYSICIAN	0.00	0.00	0.00	0.00		XXX
98920		D	PHYSICIAN PHONE CONSULT	0.00	0.00	0.00	0.00		XXX
98921		D	PHYSICIAN PHONE CONSULT	0.00	0.00	0.00	0.00		XXX
98922		D	PHYSICIAN PHONE CONSULT	0.00	0.00	0.00	0.00		XXX
99000		B	SPECIMEN HANDLING	0.00	0.00	0.00	0.00		XXX
99001		B	SPECIMEN HANDLING	0.00	0.00	0.00	0.00		XXX
99002		B	DEVICE HANDLING	0.00	0.00	0.00	0.00		XXX
99024		B	POST-OP FOLLOW-UP VISIT	0.00	0.00	0.00	0.00		XXX
99025		B	INITIAL SURGICAL EVALUATION	0.00	0.00	0.00	0.00		XXX
99050		B	POST-OP FOLLOW-UP VISIT	0.00	0.00	0.00	0.00		XXX
99052		B	MEDICAL SERVICES AT NIGHT	0.00	0.00	0.00	0.00		XXX
99054		B	MEDICAL SERVICES, UNUSUAL HRS	0.00	0.00	0.00	0.00		XXX
99056		B	NON-OFFICE MEDICAL SERVICES	0.00	0.00	0.00	0.00		XXX
99058		B	OFFICE EMERGENCY CARE	0.00	0.00	0.00	0.00		XXX
99062		D	EMERGENCY CARE SERVICES	0.00	0.00	0.00	0.00		XXX
99064		D	EMERGENCY CARE SERVICES	0.00	0.00	0.00	0.00		XXX
99065		D	EMERGENCY CARE SERVICES	0.00	0.00	0.00	0.00		XXX
99070		B	SPECIAL SUPPLIES	0.00	0.00	0.00	0.00		XXX
99071		B	PATIENT EDUCATION MATERIALS	0.00	0.00	0.00	0.00		XXX
99075		N	MEDICAL TESTIMONY	0.00	0.00	0.00	0.00		XXX
99078		B	GROUP HEALTH EDUCATION	0.00	0.00	0.00	0.00		XXX
99080		B	SPECIAL REPORTS OR FORMS	0.00	0.00	0.00	0.00		XXX
99082		C	UNUSUAL PHYSICIAN TRAVEL	0.00	0.00	0.00	0.00		XXX
99090		B	COMPUTER DATA ANALYSIS	0.00	0.00	0.00	0.00		XXX
99100		X	SPECIAL ANESTHESIA SERVICE	0.00	0.00	0.00	0.00		XXX
99116		X	ANESTHESIA WITH HYPOTHERMIA	0.00	0.00	0.00	0.00		XXX
99135		X	SPECIAL ANESTHESIA PROCEDURE	0.00	0.00	0.00	0.00		XXX
99140		X	EMERGENCY ANESTHESIA	0.00	0.00	0.00	0.00		XXX
99150		B	PROLONGED MD ATTENDANCE	0.00	0.00	0.00	0.00		XXX
99151		B	PROLONGED MD ATTENDANCE	0.00	0.00	0.00	0.00		XXX
99152		D	NEWBORN RESUSCITATION	0.00	0.00	0.00	0.00		XXX
99160		V	CRITICAL CARE, EACH HOUR	0.00	0.00	0.00	0.00		XXX
99162		V	CRITICAL CARE, ADDED 30 MIN	0.00	0.00	0.00	0.00		XXX
99170		D	GASTRIC INTUBATION TREATMENT	0.00	0.00	0.00	0.00		XXX
99171		D	CRITICAL CARE, FOLLOW-UP	0.00	0.00	0.00	0.00		XXX
99172		D	CRITICAL CARE, FOLLOW-UP	0.00	0.00	0.00	0.00		XXX
99173		D	CRITICAL CARE, FOLLOW-UP	0.00	0.00	0.00	0.00		XXX
99174		D	CRITICAL CARE, FOLLOW-UP	0.00	0.00	0.00	0.00		XXX
99175		A	INDUCTION OF VOMITING	0.00	1.40	0.10	1.50		XXX
99178		C	DEVELOPMENT EVALUATION TESTS	0.00	0.00	0.00	0.00		XXX
99180		A	HYPERBARIC OXYGEN, INITIAL	0.00	1.99	0.17	2.16		XXX
99182		A	HYPERBARIC OXYGEN, SUBSEQUENT	0.00	1.55	0.14	1.69		XXX
99185		A	REGIONAL HYPOTHERMIA	0.00	0.65	0.04	0.69		XXX
99186		A	TOTAL BODY HYPOTHERMIA	0.00	1.79	0.56	2.35		XXX
99190		A	SPECIAL PUMP SERVICES	1.59	1.51	0.27	3.37	2	000
99191		A	SPECIAL PUMP SERVICES	1.20	0.78	0.06	2.04	2	000
99192		A	SPECIAL PUMP SERVICES	0.80	0.67	0.05	1.52	2	000
99195		A	PHLEBOTOMY	0.00	0.44	0.03	0.47		XXX
99199		C	SPECIAL SERVICE OR REPORT	0.00	0.00	0.00	0.00		XXX
99201		A	OFFICE/OUTPATIENT VISIT, NEW	0.40	0.39	0.04	0.83	1	XXX
99202		A	OFFICE/OUTPATIENT VISIT, NEW	0.77	0.49	0.05	1.31	1	XXX
99203		A	OFFICE/OUTPATIENT VISIT, NEW	1.14	0.57	0.06	1.77	1	XXX
99204		A	OFFICE/OUTPATIENT VISIT, NEW	1.68	0.83	0.08	2.59	1	XXX
99205		A	OFFICE/OUTPATIENT VISIT, NEW	2.22	0.91	0.09	3.22	1	XXX
99211		A	OFFICE/OUTPATIENT VISIT, EST	0.21	0.20	0.02	0.43	1	XXX
99212		A	OFFICE/OUTPATIENT VISIT, EST	0.40	0.30	0.02	0.72	1	XXX
99213		A	OFFICE/OUTPATIENT VISIT, EST	0.58	0.39	0.03	1.00	1	XXX
99214		A	OFFICE/OUTPATIENT VISIT, EST	0.93	0.55	0.04	1.52	1	XXX
99215		A	OFFICE/OUTPATIENT VISIT, EST	1.46	0.81	0.07	2.34	1	XXX
99221		A	INITIAL HOSPITAL CARE	1.13	0.72	0.06	1.91	1	XXX
99222		A	INITIAL HOSPITAL CARE	1.84	1.10	0.09	3.03	1	XXX
99223		A	INITIAL HOSPITAL CARE	2.54	1.20	0.09	3.83	1	XXX
99231		A	SUBSEQUENT HOSPITAL CARE	0.58	0.40	0.03	1.01	1	XXX
99232		A	SUBSEQUENT HOSPITAL CARE	0.93	0.48	0.04	1.45	1	XXX
99233		A	SUBSEQUENT HOSPITAL CARE	1.26	0.64	0.05	1.95	1	XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
99238		A	HOSPITAL DISCHARGE DAY	1.14	0.56	0.04	1.74	1	XXX
99241		A	OFFICE CONSULTATION	0.59	0.63	0.07	1.29	1	XXX
99242		A	OFFICE CONSULTATION	1.17	0.77	0.08	2.02	1	XXX
99243		A	OFFICE CONSULTATION	1.56	0.96	0.09	2.61	1	XXX
99244		A	OFFICE CONSULTATION	2.29	1.26	0.11	3.66	1	XXX
99245		A	OFFICE CONSULTATION	3.02	1.69	0.15	4.86	1	XXX
99251		A	INITIAL INPATIENT CONSULT	0.60	0.71	0.08	1.39	1	XXX
99252		A	INITIAL INPATIENT CONSULT	1.18	0.80	0.09	2.07	1	XXX
99253		A	INITIAL INPATIENT CONSULT	1.57	1.00	0.10	2.67	1	XXX
99254		A	INITIAL INPATIENT CONSULT	2.30	1.28	0.11	3.69	1	XXX
99255		A	INITIAL INPATIENT CONSULT	3.03	1.67	0.14	4.84	1	XXX
99261		A	FOLLOW-UP INPATIENT CONSULT	0.50	0.34	0.03	0.87	1	XXX
99262		A	FOLLOW-UP INPATIENT CONSULT	0.96	0.49	0.04	1.49	1	XXX
99263		A	FOLLOW-UP INPATIENT CONSULT	1.41	0.71	0.05	2.17	1	XXX
99271		A	CONFIRMATORY CONSULTATION	0.50	0.64	0.07	1.21	2	XXX
99272		A	CONFIRMATORY CONSULTATION	0.91	0.75	0.09	1.75	2	XXX
99273		A	CONFIRMATORY CONSULTATION	1.28	0.93	0.11	2.32	2	XXX
99274		A	CONFIRMATORY CONSULTATION	1.84	1.17	0.12	3.13	2	XXX
99275		A	CONFIRMATORY CONSULTATION	2.46	1.51	0.15	4.12	2	XXX
99281		A	EMERGENCY DEPT VISIT	0.30	0.30	0.02	0.62	1	XXX
99282		A	EMERGENCY DEPT VISIT	0.52	0.40	0.03	0.95	1	XXX
99283		A	EMERGENCY DEPT VISIT	0.92	0.53	0.04	1.49	1	XXX
99284		A	EMERGENCY DEPT VISIT	1.79	0.75	0.06	2.60	1	XXX
99285		A	EMERGENCY DEPT VISIT	2.79	1.19	0.09	4.07	1	XXX
99288		B	DIRECT ADVANCED LIFE SUPPORT	0.00	0.00	0.00	0.00		XXX
99291		A	CRITICAL CARE, FIRST HOUR	2.49	1.51	0.11	4.11	1	XXX
99292		A	CRITICAL CARE, ADD'L 30 MIN	1.26	0.68	0.05	1.99	2	XXX
99301		A	NURSING FACILITY CARE	0.92	0.48	0.03	1.43	1	XXX
99302		A	NURSING FACILITY CARE	1.14	0.53	0.04	1.71	1	XXX
99303		A	NURSING FACILITY CARE	1.52	0.74	0.06	2.32	1	XXX
99311		A	NURSING FACILITY CARE, SUBSEQ	0.51	0.35	0.03	0.89	1	XXX
99312		A	NURSING FACILITY CARE, SUBSEQ	0.72	0.43	0.03	1.18	1	XXX
99313		A	NURSING FACILITY CARE, SUBSEQ	1.06	0.50	0.04	1.60	1	XXX
99321		A	REST HOME VISIT, NEW PATIENT	0.75	0.38	0.03	1.16	2	XXX
99322		A	REST HOME VISIT, NEW PATIENT	1.06	0.56	0.05	1.67	2	XXX
99323		A	REST HOME VISIT, NEW PATIENT	1.36	0.78	0.06	2.20	2	XXX
99331		A	REST HOME VISIT, ESTAB PAT	0.64	0.29	0.02	0.95	2	XXX
99332		A	REST HOME VISIT, ESTAB PAT	0.85	0.38	0.03	1.26	2	XXX
99333		A	REST HOME VISIT, ESTAB PAT	1.06	0.47	0.03	1.56	2	XXX
99341		A	HOME VISIT, NEW PATIENT	0.96	0.57	0.05	1.58	2	XXX
99342		A	HOME VISIT, NEW PATIENT	1.31	0.64	0.05	2.00	2	XXX
99343		A	HOME VISIT, NEW PATIENT	1.72	0.81	0.06	2.59	2	XXX
99351		A	HOME VISIT, ESTAB PATIENT	0.71	0.47	0.04	1.22	2	XXX
99352		A	HOME VISIT, ESTAB PATIENT	1.00	0.57	0.04	1.61	2	XXX
99353		A	HOME VISIT, ESTAB PATIENT	1.31	0.66	0.05	2.02	2	XXX
99361		B	PHYSICIAN/TEAM CONFERENCE	0.00	0.00	0.00	0.00		XXX
99362		B	PHYSICIAN/TEAM CONFERENCE	0.00	0.00	0.00	0.00		XXX
99371		B	PHYSICIAN PHONE CONSULTATION	0.00	0.00	0.00	0.00		XXX
99372		B	PHYSICIAN PHONE CONSULTATION	0.00	0.00	0.00	0.00		XXX
99373		B	PHYSICIAN PHONE CONSULTATION	0.00	0.00	0.00	0.00		XXX
99381		N	PREVENTIVE VISIT, NEW, INFANT	0.00	0.00	0.00	0.00		XXX
99382		N	PREVENTIVE VISIT, NEW, 1-4	0.00	0.00	0.00	0.00		XXX
99383		N	PREVENTIVE VISIT, NEW, 5-11	0.00	0.00	0.00	0.00		XXX
99384		N	PREVENTIVE VISIT, NEW 12-17	0.00	0.00	0.00	0.00		XXX
99385		N	PREVENTIVE VISIT, NEW 18-39	0.00	0.00	0.00	0.00		XXX
99386		N	PREVENTIVE VISIT, 40-64	0.00	0.00	0.00	0.00		XXX
99387		N	PREVENTIVE VISIT, NEW, 65&OVER	0.00	0.00	0.00	0.00		XXX
99391		N	PREVENTIVE VISIT, EST, INFANT	0.00	0.00	0.00	0.00		XXX
99392		N	PREVENTIVE VISIT, EST, 1-4	0.00	0.00	0.00	0.00		XXX
99393		N	PREVENTIVE VISIT, EST, 5-11	0.00	0.00	0.00	0.00		XXX
99394		N	PREVENTIVE VISIT, EST, 12-17	0.00	0.00	0.00	0.00		XXX
99395		N	PREVENTIVE VISIT, EST, 18-39	0.00	0.00	0.00	0.00		XXX
99396		N	PREVENTIVE VISIT, EST, 40-64	0.00	0.00	0.00	0.00		XXX
99397		N	PREVENTIVE VISIT, EST, 65&OVER	0.00	0.00	0.00	0.00		XXX
99401		N	PREVENTIVE COUNSELING, INDIV	0.00	0.00	0.00	0.00		XXX
99402		N	PREVENTIVE COUNSELING, INDIV	0.00	0.00	0.00	0.00		XXX
99403		N	PREVENTIVE COUNSELING, INDIV	0.00	0.00	0.00	0.00		XXX
99404		N	PREVENTIVE COUNSELING, INDIV	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS*	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
99411		N	PREVENTIVE COUNSELING, GROUP	0.00	0.00	0.00	0.00		XXX
99412		N	PREVENTIVE COUNSELING, GROUP	0.00	0.00	0.00	0.00		XXX
99420		N	HEALTH RISK ASSESSMENT TEST	0.00	0.00	0.00	0.00		XXX
99429		N	UNLISTED PREVENTIVE SERVICE	0.00	0.00	0.00	0.00		XXX
99431		C	INITIAL CARE, NORMAL NEWBORN	0.00	0.00	0.00	0.00		XXX
99432		C	NEWBORN CARE NOT IN HOSPITAL	0.00	0.00	0.00	0.00		XXX
99433		C	NORMAL NEWBORN CARE, HOSPITAL	0.00	0.00	0.00	0.00		XXX
99438		C	INFANT CARE TO AGE ONE YEAR	0.00	0.00	0.00	0.00		XXX
99440		C	NEWBORN RESUSCITATION	0.00	0.00	0.00	0.00		XXX
99499		C	UNLISTED E/M SERVICE	0.00	0.00	0.00	0.00		XXX

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ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
A0010		X	AMBULANCE SERVICE, (BLS) BASE RATE	0.00	0.00	0.00	0.00		XXX
A0020		X	AMBULANCE SERVICE, (BLS) PER MILE	0.00	0.00	0.00	0.00		XXX
A0021		X	AMBULANCE SERVICE, OUTSIDE STATE	0.00	0.00	0.00	0.00		XXX
A0030		X	AMBULANCE SERVICE, AIR SERVICE	0.00	0.00	0.00	0.00		XXX
A0040		X	AMBULANCE SERVICE, HELICOPTER	0.00	0.00	0.00	0.00		XXX
A0050		X	AMBULANCE SERVICE, EMERGENCY	0.00	0.00	0.00	0.00		XXX
A0060		X	AMBULANCE SERVICE, WAITING TIME	0.00	0.00	0.00	0.00		XXX
A0070		X	AMBULANCE SERVICE, OXYGEN	0.00	0.00	0.00	0.00		XXX
A0080		X	NON-EMERGENCY TRANSPORTATION	0.00	0.00	0.00	0.00		XXX
A0090		X	NON-EMERGENCY TRANSPORTATION	0.00	0.00	0.00	0.00		XXX
A0100		N	NON-EMERGENCY TRANSPORTATION	0.00	0.00	0.00	0.00		XXX
A0110		N	NON-EMERGENCY TRANSPORTATION	0.00	0.00	0.00	0.00		XXX
A0120		X	NON-EMERGENCY TRANSPORTATION	0.00	0.00	0.00	0.00		XXX
A0130		N	NON-EMERGENCY TRANSPORTATION	0.00	0.00	0.00	0.00		XXX
A0140		X	NON-EMERGENCY TRANSPORTATION	0.00	0.00	0.00	0.00		XXX
A0150		X	NON-EMERGENCY TRANSPORTATION	0.00	0.00	0.00	0.00		XXX
A0160		N	NON-EMERGENCY TRANSPORTATION	0.00	0.00	0.00	0.00		XXX
A0170		N	NON-EMERGENCY TRANSPORTATION	0.00	0.00	0.00	0.00		XXX
A0180		N	NON-EMERGENCY TRANSPORTATION	0.00	0.00	0.00	0.00		XXX
A0190		N	NON-EMERGENCY TRANSPORTATION	0.00	0.00	0.00	0.00		XXX
A0200		N	NON-EMERGENCY TRANSPORTATION	0.00	0.00	0.00	0.00		XXX
A0210		N	NON-EMERGENCY TRANSPORTATION	0.00	0.00	0.00	0.00		XXX
A0215		X	AMBULANCE SERVICE, MISCELLANEOUS	0.00	0.00	0.00	0.00		XXX
A0220		X	AMBULANCE SERVICE, (ALS) BASE	0.00	0.00	0.00	0.00		XXX
A0221		X	AMBULANCE SERVICE, (ALS) PER MILE	0.00	0.00	0.00	0.00		XXX
A0222		X	AMBULANCE SERVICE, RETURN TRIP	0.00	0.00	0.00	0.00		XXX
A0223		X	AMBULANCE SERVICE, (ALS) BASE	0.00	0.00	0.00	0.00		XXX
A0225		X	AMBULANCE SERVICE, NEONATAL	0.00	0.00	0.00	0.00		XXX
A0999		X	UNLISTED AMBULANCE SERVICE	0.00	0.00	0.00	0.00		XXX
A2000		A	MANIPULATION OF SPINE	0.38	0.30	0.01	0.69	2	XXX
A4190		P	TRANSPARENT FILM	0.00	0.00	0.00	0.00		XXX
A4200		P	GAUZE PADS, STERILE OR NONSTERILE	0.00	0.00	0.00	0.00		XXX
A4202		P	GAUZE BANDAGE, ELASTIC	0.00	0.00	0.00	0.00		XXX
A4203		P	GAUZE BANDAGE, NON-ELASTIC	0.00	0.00	0.00	0.00		XXX
A4204		P	ABSORPTIVE DRESSING	0.00	0.00	0.00	0.00		XXX
A4205		P	NON-ABSORPTIVE DRESSING	0.00	0.00	0.00	0.00		XXX
A4206		P	SYRINGE WITH NEEDLE, STERILE 1CC	0.00	0.00	0.00	0.00		XXX
A4207		P	SYRINGE WITH NEEDLE, STERILE 2CC	0.00	0.00	0.00	0.00		XXX
A4208		P	SYRINGE WITH NEEDLE, STERILE 3CC	0.00	0.00	0.00	0.00		XXX
A4209		P	SYRINGE WITH NEEDLE, STERILE 5CC+	0.00	0.00	0.00	0.00		XXX
A4210		N	NEEDLE-FREE INJECTION DEVICE	0.00	0.00	0.00	0.00		XXX
A4213		P	SYRINGE, STERILE, 20 CC OR GREATER	0.00	0.00	0.00	0.00		XXX
A4214		P	STERILE SALINE OR WATER, 30 CC	0.00	0.00	0.00	0.00		XXX
A4215		P	NEEDLES ONLY, STERILE, ANY SIZE	0.00	0.00	0.00	0.00		XXX
A4216		P	HEMOSTATIC CELLULOSE ANY SIZE	0.00	0.00	0.00	0.00		XXX
A4244		P	ALCOHOL OR PEROXIDE, PER PINT	0.00	0.00	0.00	0.00		XXX
A4245		P	ALCOHOL WIPES, PER BOX	0.00	0.00	0.00	0.00		XXX
A4246		P	BETADINE OR PHISOX SOLUTION	0.00	0.00	0.00	0.00		XXX
A4247		P	BETADINE OR IODINE SWABS/WIPES	0.00	0.00	0.00	0.00		XXX
A4250		N	URINE TEST OR REAGENT STRIPS	0.00	0.00	0.00	0.00		XXX
A4253		P	BLOOD GLUCOSE TEST	0.00	0.00	0.00	0.00		XXX
A4256		P	NORMAL, LOW AND HIGH CAL SOLUTION	0.00	0.00	0.00	0.00		XXX
A4259		P	LANCETS, PER BOX	0.00	0.00	0.00	0.00		XXX
A4265		P	PARAFFIN	0.00	0.00	0.00	0.00		XXX
A4300		X	IMPLANTABLE VASCULAR ACCESS PORTAL	0.00	0.00	0.00	0.00		XXX
A4310		P	INSERTION TRAY W/O DRAINAGE BAG	0.00	0.00	0.00	0.00		XXX
A4311		P	INSERTION TRAY W/O DRAINAGE BAG	0.00	0.00	0.00	0.00		XXX
A4312		P	INSERTION TRAY W/O DRAINAGE BAG	0.00	0.00	0.00	0.00		XXX
A4313		P	INSERTION TRAY W/O DRAINAGE BAG	0.00	0.00	0.00	0.00		XXX
A4314		P	INSERTION TRAY WITH DRAINAGE BAG	0.00	0.00	0.00	0.00		XXX
A4315		P	INSERTION TRAY WITH DRAINAGE BAG	0.00	0.00	0.00	0.00		XXX
A4316		P	INSERTION TRAY WITH DRAINAGE BAG	0.00	0.00	0.00	0.00		XXX
A4320		P	IRRIGATION TRAY FOR BLADDER	0.00	0.00	0.00	0.00		XXX
A4322		P	IRRIGATION SYRINGE, BULB OR PISTON	0.00	0.00	0.00	0.00		XXX
A4323		P	STERILE SALINE IRRIGATION SOLUTION	0.00	0.00	0.00	0.00		XXX
A4326		P	MALE EXTERNAL CATHETER	0.00	0.00	0.00	0.00		XXX
A4327		P	FEMALE EXTERNAL URINARY COLLECTION	0.00	0.00	0.00	0.00		XXX
A4328		P	FEMALE EXTERNAL URINARY COLLECTION	0.00	0.00	0.00	0.00		XXX
A4329		P	EXTERNAL CATHETER STARTER SET	0.00	0.00	0.00	0.00		XXX

ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
A4330		P	PERIANAL FECAL COLLECTION POUCH	0.00	0.00	0.00	0.00		XXX
A4335		P	INCONTINENCE SUPPLY; MISCELLANEOUS	0.00	0.00	0.00	0.00		XXX
A4338		P	INDWELLING CATHETER; FOLEY TYPE	0.00	0.00	0.00	0.00		XXX
A4340		P	INDWELLING CATHETER; SPEC TYPE	0.00	0.00	0.00	0.00		XXX
A4344		P	INDWELLING CATHETER; FOLEY TYPE	0.00	0.00	0.00	0.00		XXX
A4346		P	INDWELLING CATHETER; FOLEY TYPE	0.00	0.00	0.00	0.00		XXX
A4347		P	MALE EXTERNAL CATHETER	0.00	0.00	0.00	0.00		XXX
A4351		P	INTERMITTENT URINARY CATHETER	0.00	0.00	0.00	0.00		XXX
A4352		P	INTERMITTENT URINARY CATHETER	0.00	0.00	0.00	0.00		XXX
A4354		P	INSERTION TRAY WITH DRAINAGE BAG	0.00	0.00	0.00	0.00		XXX
A4355		P	IRRIGATION TUBING SET	0.00	0.00	0.00	0.00		XXX
A4356		P	EXTERNAL URETHRAL CLAMP DEVICE	0.00	0.00	0.00	0.00		XXX
A4357		P	BEDSIDE DRAINAGE BAG, DAY OR NIGHT	0.00	0.00	0.00	0.00		XXX
A4358		P	URINARY LEG BAG; VINYL	0.00	0.00	0.00	0.00		XXX
A4359		P	URINARY SUSPENSORY WITHOUT LEG BAG	0.00	0.00	0.00	0.00		XXX
A4361		P	OSTOMY FACEPLATE	0.00	0.00	0.00	0.00		XXX
A4362		P	SKIN BARRIER; SOLID, 4 X 4	0.00	0.00	0.00	0.00		XXX
A4363		P	SKIN BARRIER; LIQUID, POWDER	0.00	0.00	0.00	0.00		XXX
A4364		P	ADHESIVE FOR OSTOMY OR CATHETER	0.00	0.00	0.00	0.00		XXX
A4367		P	OSTOMY BELT	0.00	0.00	0.00	0.00		XXX
A4397		P	IRRIGATION SUPPLY; SLEEVE	0.00	0.00	0.00	0.00		XXX
A4398		P	IRRIGATION SUPPLY; BAGS	0.00	0.00	0.00	0.00		XXX
A4399		P	IRRIGATION SUPPLY; CONE/CATHETER	0.00	0.00	0.00	0.00		XXX
A4400		P	OSTOMY IRRIGATION SET	0.00	0.00	0.00	0.00		XXX
A4402		P	LUBRICANT	0.00	0.00	0.00	0.00		XXX
A4404		P	OSTOMY RINGS	0.00	0.00	0.00	0.00		XXX
A4421		P	OSTOMY SUPPLY; MISCELLANEOUS	0.00	0.00	0.00	0.00		XXX
A4454		P	TAPE, ALL TYPES, ALL SIZES	0.00	0.00	0.00	0.00		XXX
A4455		P	ADHESIVE REMOVER OR SOLVENT	0.00	0.00	0.00	0.00		XXX
A4460		P	ELASTIC BANDAGE	0.00	0.00	0.00	0.00		XXX
A4470		P	GRAVLEE JET WASHER	0.00	0.00	0.00	0.00		XXX
A4480		P	VABRA ASPIRATOR	0.00	0.00	0.00	0.00		XXX
A4490		N	SURGICAL STOCKINGS ABOVE KNEE	0.00	0.00	0.00	0.00		XXX
A4495		N	SURGICAL STOCKINGS THIGH LENGTH	0.00	0.00	0.00	0.00		XXX
A4500		N	SURGICAL STOCKINGS BELOW KNEE	0.00	0.00	0.00	0.00		XXX
A4510		N	SURGICAL STOCKINGS FULL LENGTH	0.00	0.00	0.00	0.00		XXX
A4550		A	SURGICAL TRAYS	0.00	1.00	0.00	1.00		XXX
A4554		N	DISPOSABLE UNDERPADS, ALL SIZES	0.00	0.00	0.00	0.00		XXX
A4555		D	PRIMARY SURGICAL DRESSING KIT	0.00	0.00	0.00	0.00		XXX
A4556		P	ELECTRODES, (E.G., APNEA MONITOR)	0.00	0.00	0.00	0.00		XXX
A4557		P	LEAD WIRES, (E.G., APNEA MONITOR)	0.00	0.00	0.00	0.00		XXX
A4558		P	CONDUCTIVE PASTE OR GEL	0.00	0.00	0.00	0.00		XXX
A4560		P	PESSARY	0.00	0.00	0.00	0.00		XXX
A4565		P	SLINGS	0.00	0.00	0.00	0.00		XXX
A4570		P	SPLINT	0.00	0.00	0.00	0.00		XXX
A4572		P	RIB BELT	0.00	0.00	0.00	0.00		XXX
A4580		P	CAST SUPPLIES	0.00	0.00	0.00	0.00		XXX
A4581		P	SUPPLIES RISSE JACKET	0.00	0.00	0.00	0.00		XXX
A4590		P	SPECIAL CASTING MATERIALS	0.00	0.00	0.00	0.00		XXX
A4610		X	MEDICATION SUPPLIES, DME USED	0.00	0.00	0.00	0.00		XXX
A4611		X	BATTERY, HEAVY DUTY; REPLACEMENT	0.00	0.00	0.00	0.00		XXX
A4612		X	BATTERY CABLES; REPLACEMENT	0.00	0.00	0.00	0.00		XXX
A4613		X	BATTERY CHARGER; REPLACEMENT	0.00	0.00	0.00	0.00		XXX
A4615		X	CANNULA, NASAL	0.00	0.00	0.00	0.00		XXX
A4616		X	TUBING (OXYGEN), PER FOOT	0.00	0.00	0.00	0.00		XXX
A4617		X	MOUTH PIECE	0.00	0.00	0.00	0.00		XXX
A4618		X	BREATHING CIRCUITS	0.00	0.00	0.00	0.00		XXX
A4619		X	FACE TENT	0.00	0.00	0.00	0.00		XXX
A4620		X	VARIABLE CONCENTRATION MASK	0.00	0.00	0.00	0.00		XXX
A4621		X	TRACHEOTOMY MASK OR COLLAR	0.00	0.00	0.00	0.00		XXX
A4622		X	TRACHEOSTOMY OR LARYNGECTOMY TUBE	0.00	0.00	0.00	0.00		XXX
A4623		X	TRACHEOSTOMY, INNER CANNULA	0.00	0.00	0.00	0.00		XXX
A4624		X	TRACHEAL SUCTION CATHETER	0.00	0.00	0.00	0.00		XXX
A4625		X	TRACHEOSTOMY CARE OR CLEANING KIT	0.00	0.00	0.00	0.00		XXX
A4626		X	TRACHEOSTOMY CLEANING BRUSH, EACH	0.00	0.00	0.00	0.00		XXX
A4627		X	SPACER, BAG OR RESERVOIR	0.00	0.00	0.00	0.00		XXX
A4630		X	REPLACEMENT BATTERIES	0.00	0.00	0.00	0.00		XXX
A4631		X	REPLACEMENT, BATTERIES	0.00	0.00	0.00	0.00		XXX
A4635		X	UNDERARM PAD, CRUTCH, REPLACEMENT	0.00	0.00	0.00	0.00		XXX

ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
A4636		X	REPLACEMENT, HANDGRIP, CANE	0.00	0.00	0.00	0.00		XXX
A4637		X	REPLACEMENT, TIP, CANE, CRUTCH	0.00	0.00	0.00	0.00		XXX
A4640		X	REPLACEMENT PAD	0.00	0.00	0.00	0.00		XXX
A4647		X	PARAMAGNETIC CONTRAST MATERIAL	0.00	0.00	0.00	0.00		XXX
A4648		X	LOW OSMOLAR CONTRAST MATERIAL	0.00	0.00	0.00	0.00		XXX
A4649		X	SURGICAL SUPPLY; MISCELLANEOUS	0.00	0.00	0.00	0.00		XXX
A4650		X	CENTRIFUGE	0.00	0.00	0.00	0.00		XXX
A4655		X	NEEDLES AND SYRINGES FOR DIALYSIS	0.00	0.00	0.00	0.00		XXX
A4660		X	SPHYGMOMANOMETER/BLOOD PRESSURE	0.00	0.00	0.00	0.00		XXX
A4663		X	BLOOD PRESSURE CUFF ONLY	0.00	0.00	0.00	0.00		XXX
A4670		X	AUTOMATIC BLOOD PRESSURE MONITOR	0.00	0.00	0.00	0.00		XXX
A4680		X	ACTIVATED CARBON FILTERS	0.00	0.00	0.00	0.00		XXX
A4690		X	DIALYZERS (ARTIFICIAL KIDNEYS)	0.00	0.00	0.00	0.00		XXX
A4700		X	STANDARD DIALYSATE SOLUTION	0.00	0.00	0.00	0.00		XXX
A4705		X	BICARBONATE DIALYSATE SOLUTION	0.00	0.00	0.00	0.00		XXX
A4712		X	WATER, STERILE	0.00	0.00	0.00	0.00		XXX
A4714		X	TREATED WATER; DEIONIZED	0.00	0.00	0.00	0.00		XXX
A4730		X	FISTULA CANNULATION SET	0.00	0.00	0.00	0.00		XXX
A4735		X	LOCAL/TOPICAL ANESTHETICS	0.00	0.00	0.00	0.00		XXX
A4740		X	SHUNT ACCESSORIES, DIALYSIS ONLY	0.00	0.00	0.00	0.00		XXX
A4750		X	BLOOD TUBING, ARTERIAL OR VENOUS	0.00	0.00	0.00	0.00		XXX
A4755		X	BLOOD TUBING, ARTERIAL AND VENOUS	0.00	0.00	0.00	0.00		XXX
A4760		X	DIALYSATE STANDARD SOLUTION	0.00	0.00	0.00	0.00		XXX
A4765		X	DIALYSATE CONCENTRATE ADDITIVES	0.00	0.00	0.00	0.00		XXX
A4770		X	BLOOD TESTING SUPPLIES	0.00	0.00	0.00	0.00		XXX
A4771		X	SERUM CLOTTING TIME TUBE, PER BOX	0.00	0.00	0.00	0.00		XXX
A4772		X	DEXTROSTICK OR GLUCOSE TEST STRIPS	0.00	0.00	0.00	0.00		XXX
A4773		X	HEMOSTIX, PER BOTTLE	0.00	0.00	0.00	0.00		XXX
A4774		X	AMMONIA TEST PAPER, PER BOX	0.00	0.00	0.00	0.00		XXX
A4780		X	STERILIZING AGENT, DIALYSIS EQUIP	0.00	0.00	0.00	0.00		XXX
A4790		X	CLEANSING AGENTS FOR EQUIPMENT	0.00	0.00	0.00	0.00		XXX
A4800		X	HEPARIN FOR DIALYSIS AND ANTIDOTE	0.00	0.00	0.00	0.00		XXX
A4820		X	HEMODIALYSIS KIT SUPPLIES	0.00	0.00	0.00	0.00		XXX
A4850		X	HEMOSTATS WITH RUBBER TIPS	0.00	0.00	0.00	0.00		XXX
A4860		X	DISPOSABLE CATHETER CAPS	0.00	0.00	0.00	0.00		XXX
A4870		X	PLUMBING AND/OR ELECTRICAL WORK	0.00	0.00	0.00	0.00		XXX
A4880		X	STORAGE TANKS UTILIZED WITH WATER	0.00	0.00	0.00	0.00		XXX
A4890		N	CONTRACTS, REPAIR AND MAINTENANCE	0.00	0.00	0.00	0.00		XXX
A4900		X	DIALYSIS (CAPD) SUPPLY KIT	0.00	0.00	0.00	0.00		XXX
A4901		X	DIALYSIS (CCPD) SUPPLY KIT	0.00	0.00	0.00	0.00		XXX
A4905		X	DIALYSIS (IPD) SUPPLY KIT	0.00	0.00	0.00	0.00		XXX
A4910		X	NON-MEDICAL SUPPLIES FOR DIALYSIS	0.00	0.00	0.00	0.00		XXX
A4912		X	GOMCO DRAIN BOTTLE	0.00	0.00	0.00	0.00		XXX
A4913		X	MISCELLANEOUS DIALYSIS SUPPLIES	0.00	0.00	0.00	0.00		XXX
A4914		X	PREPARATION KITS	0.00	0.00	0.00	0.00		XXX
A4918		X	VENOUS PRESSURE CLAMPS, EACH	0.00	0.00	0.00	0.00		XXX
A4919		X	DIALYZER HOLDER, EACH	0.00	0.00	0.00	0.00		XXX
A4920		X	HARVARD PRESSURE CLAMP, EACH	0.00	0.00	0.00	0.00		XXX
A4921		X	MEASURING CYLINDER, ANY SIZE	0.00	0.00	0.00	0.00		XXX
A4927		X	GLOVES, STERILE OR NON-STERILE	0.00	0.00	0.00	0.00		XXX
A5051		P	POUCH, CLOSED; WITH BARRIER	0.00	0.00	0.00	0.00		XXX
A5052		P	POUCH, CLOSED; WITHOUT BARRIER	0.00	0.00	0.00	0.00		XXX
A5053		P	POUCH, CLOSED; USE ON FACEPLATE	0.00	0.00	0.00	0.00		XXX
A5054		P	POUCH, CLOSED; USE ON BARRIER	0.00	0.00	0.00	0.00		XXX
A5055		P	STOMA CAP	0.00	0.00	0.00	0.00		XXX
A5061		P	POUCH, DRAINABLE; WITH BARRIER	0.00	0.00	0.00	0.00		XXX
A5062		P	POUCH, DRAINABLE; WITHOUT BARRIER	0.00	0.00	0.00	0.00		XXX
A5063		P	POUCH, DRAINABLE; USE ON BARRIER	0.00	0.00	0.00	0.00		XXX
A5064		P	POUCH, DRAINABLE; WITH FACEPLATE	0.00	0.00	0.00	0.00		XXX
A5065		P	POUCH, DRAINABLE; USE ON FACEPLATE	0.00	0.00	0.00	0.00		XXX
A5071		P	POUCH, URINARY; WITH BARRIER	0.00	0.00	0.00	0.00		XXX
A5072		P	POUCH, URINARY; WITHOUT BARRIER	0.00	0.00	0.00	0.00		XXX
A5073		P	POUCH, URINARY; USE ON BARRIER	0.00	0.00	0.00	0.00		XXX
A5074		P	POUCH, URINARY; WITH FACEPLATE	0.00	0.00	0.00	0.00		XXX
A5075		P	POUCH, URINARY; USE ON FACEPLATE	0.00	0.00	0.00	0.00		XXX
A5081		P	CONTINENT DEVICE; PLUG	0.00	0.00	0.00	0.00		XXX
A5082		P	CONTINENT DEVICE; CATHETER	0.00	0.00	0.00	0.00		XXX
A5093		P	OSTOMY ACCESSORY; CONVEX INSERT	0.00	0.00	0.00	0.00		XXX
A5102		P	BEDSIDE DRAINAGE BOTTLE	0.00	0.00	0.00	0.00		XXX

ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPs	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL - PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
A5105		P	URINARY SUSPENSORY; WITH LEG BAG	0.00	0.00	0.00	0.00		XXX
A5112		P	URINARY LEG BAG; LATEX	0.00	0.00	0.00	0.00		XXX
A5113		P	LEG STRAP; LATEX, PER SET	0.00	0.00	0.00	0.00		XXX
A5114		P	LEG STRAP; FOAM OR FABRIC	0.00	0.00	0.00	0.00		XXX
A5119		P	SKIN BARRIER; WIPES, BOX PER 50	0.00	0.00	0.00	0.00		XXX
A5121		P	SKIN BARRIER; SOLID, 6 X 6	0.00	0.00	0.00	0.00		XXX
A5122		P	SKIN BARRIER; SOLID, 8 X 8	0.00	0.00	0.00	0.00		XXX
A5123		P	SKIN BARRIER; WITH FLANGE	0.00	0.00	0.00	0.00		XXX
A5126		P	ADHESIVE; DISC OR FOAM PAD	0.00	0.00	0.00	0.00		XXX
A5131		P	APPLIANCE CLEANER	0.00	0.00	0.00	0.00		XXX
A5149		P	INCONTINENCE/OSTOMY SUPPLY	0.00	0.00	0.00	0.00		XXX
A9150		E	NON-PRESCRIPTION DRUGS	0.00	0.00	0.00	0.00		XXX
A9160		N	NON-COVERED SVC. BY PODIATRIST	0.00	0.00	0.00	0.00		XXX
A9170		N	NON-COVERED SVC. BY CHIROPRACTOR	0.00	0.00	0.00	0.00		XXX
A9180		N	NATUROPATHS	0.00	0.00	0.00	0.00		XXX
A9190		N	PERSONAL ITEMS	0.00	0.00	0.00	0.00		XXX
A9250		X	NURSING HOME RENTALS	0.00	0.00	0.00	0.00		XXX
A9260		X	NON-CERTIFIED PHYSICAL THERAPISTS	0.00	0.00	0.00	0.00		XXX
A9270		N	NONCOVERED ITEM OR SERVICE	0.00	0.00	0.00	0.00		XXX
A9280		X	REIMBURSEMENT INCLUDED IN ANOTHER	0.00	0.00	0.00	0.00		XXX
A9290		X	DESCRIPTION DOES NOT INDICATE HOSP	0.00	0.00	0.00	0.00		XXX
D0110		C	INITIAL ORAL EXAMINATION	0.00	0.00	0.00	0.00		XXX
D0120		C	PERIODIC ORAL EXAMINATION	0.00	0.00	0.00	0.00		XXX
D0130		C	EMERGENCY ORAL EXAMINATION	0.00	0.00	0.00	0.00		XXX
D0210		C	INTRAORAL - COMPLETE SERIES	0.00	0.00	0.00	0.00		XXX
D0220		C	INTRAORAL- PERIAPICAL-FIRST FILM	0.00	0.00	0.00	0.00		XXX
D0230		C	INTRAORAL -PERIAPICAL EACH ADDIT	0.00	0.00	0.00	0.00		XXX
D0240		C	INTRAORAL- OCCLUSAL FILM	0.00	0.00	0.00	0.00		XXX
D0250		C	EXTRAORAL--FIRST FILM	0.00	0.00	0.00	0.00		XXX
D0260		C	EXTRAORAL- EACH ADDITIONAL FILM	0.00	0.00	0.00	0.00		XXX
D0270		C	BITEWING- SINGLE FILM	0.00	0.00	0.00	0.00		XXX
D0272		C	BITEWINGS- TWO FILMS	0.00	0.00	0.00	0.00		XXX
D0274		C	BITEWINGS- FOUR FILMS	0.00	0.00	0.00	0.00		XXX
D0275		D	BITEWINGS-EACH ADDITIONAL FILM	0.00	0.00	0.00	0.00		XXX
D0290		C	SKULL AND FACIAL BONE, SURVEY FILM	0.00	0.00	0.00	0.00		XXX
D0310		C	SALIOGRAPHY	0.00	0.00	0.00	0.00		XXX
D0320		C	TEMPOROMANDIBULAR JOINT ARTHROGRAM	0.00	0.00	0.00	0.00		XXX
D0321		C	OTHER TEMPOROMANDIBULAR JOINT FILM	0.00	0.00	0.00	0.00		XXX
D0322		C	TOMOGRAPHIC SURVEY	0.00	0.00	0.00	0.00		XXX
D0330		C	PANORAMIC FILM	0.00	0.00	0.00	0.00		XXX
D0340		C	CEPHALOMETRIC FILM	0.00	0.00	0.00	0.00		XXX
D0410		D	BACTERIOLOGIC STUDIES	0.00	0.00	0.00	0.00		XXX
D0415		C	BACTERIOLOGIC STUDIES	0.00	0.00	0.00	0.00		XXX
D0420		D	CARIES SUSCEPTIBILITY TESTS	0.00	0.00	0.00	0.00		XXX
D0425		C	CARIES SUSCEPTIBILITY TESTS	0.00	0.00	0.00	0.00		XXX
D0460		C	PULP VITALITY TESTS	0.00	0.00	0.00	0.00		XXX
D0470		C	DIAGNOSTIC CASTS	0.00	0.00	0.00	0.00		XXX
D0471		C	DIAGNOSTIC PHOTOGRAPHS	0.00	0.00	0.00	0.00		XXX
D0501		C	HISTOPATHOLOGIC EXAMINATIONS	0.00	0.00	0.00	0.00		XXX
D0502		C	OTHER ORAL PATHOLOGY PROCEDURES	0.00	0.00	0.00	0.00		XXX
D0999		C	UNSPECIFIED DIAGNOSTIC PROCEDURE	0.00	0.00	0.00	0.00		XXX
D1110		C	PROPHYLAXIS - ADULT	0.00	0.00	0.00	0.00		XXX
D1120		C	PROPHYLAXIS - CHILD	0.00	0.00	0.00	0.00		XXX
D1201		C	TOPICAL APPLICATION OF FLUORIDE	0.00	0.00	0.00	0.00		XXX
D1202		D	TOPICAL APPLICATION OF FLUORIDE	0.00	0.00	0.00	0.00		XXX
D1203		C	TOPICAL APPLICATION OF FLUORIDE	0.00	0.00	0.00	0.00		XXX
D1204		C	TOPICAL APPLICATION OF FLUORIDE	0.00	0.00	0.00	0.00		XXX
D1205		C	TOPICAL APPLICATION/FLUORIDE	0.00	0.00	0.00	0.00		XXX
D1310		C	DIETARY PLANNING	0.00	0.00	0.00	0.00		XXX
D1330		C	ORAL HYGIENE INSTRUCTION	0.00	0.00	0.00	0.00		XXX
D1351		C	SEALANT - PER TOOTH	0.00	0.00	0.00	0.00		XXX
D1510		C	SPACE MAINTAINER -FIXED-UNILATERAL	0.00	0.00	0.00	0.00		XXX
D1515		C	SPACE MAINTAINER -FIXED-BILATERAL	0.00	0.00	0.00	0.00		XXX
D1520		C	SPACE MAINTAINER -REMOVABLE	0.00	0.00	0.00	0.00		XXX
D1525		C	SPACE MAINTAINER - REMOVABLE	0.00	0.00	0.00	0.00		XXX
D1550		C	RECEMENTATION OF SPACE MAINTAINER	0.00	0.00	0.00	0.00		XXX
D2110		C	AMALGAM-ONE SURFACE, PRIMARY	0.00	0.00	0.00	0.00		XXX
D2120		C	AMALGAM-TWO SURFACES, PRIMARY	0.00	0.00	0.00	0.00		XXX
D2130		C	AMALGAM-THREE SURFACES, PRIMARY	0.00	0.00	0.00	0.00		XXX

ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
D2131		C	AMALGAM-FOUR SURFACES, PRIMARY	0.00	0.00	0.00	0.00		XXX
D2140		C	AMALGAM- ONE SURFACE, PERMANENT	0.00	0.00	0.00	0.00		XXX
D2150		C	AMALGAM- TWO SURFACES, PERMANENT	0.00	0.00	0.00	0.00		XXX
D2160		C	AMALGAM- THREE SURFACES, PERMANENT	0.00	0.00	0.00	0.00		XXX
D2161		C	AMALGAM- FOUR OR MORE SURFACES	0.00	0.00	0.00	0.00		XXX
D2210		C	SILICATE CEMENT - PER RESTORATION	0.00	0.00	0.00	0.00		XXX
D2330		C	RESIN-ONE SURFACE	0.00	0.00	0.00	0.00		XXX
D2331		C	RESIN-TWO SURFACES	0.00	0.00	0.00	0.00		XXX
D2332		C	RESIN-THREE SURFACES	0.00	0.00	0.00	0.00		XXX
D2335		C	RESIN - FOUR OR MORE SURFACES	0.00	0.00	0.00	0.00		XXX
D2336		C	COMPOSITE RESIN	0.00	0.00	0.00	0.00		XXX
D2380		C	RESIN-ONE SURFACE	0.00	0.00	0.00	0.00		XXX
D2381		C	RESIN-TWO SURFACES	0.00	0.00	0.00	0.00		XXX
D2382		C	RESIN-THREE OR MORE SURFACES	0.00	0.00	0.00	0.00		XXX
D2385		C	RESIN-ONE SURFACE	0.00	0.00	0.00	0.00		XXX
D2386		C	RESIN-TWO SURFACES	0.00	0.00	0.00	0.00		XXX
D2387		C	RESIN-THREE OR MORE SURFACES	0.00	0.00	0.00	0.00		XXX
D2410		C	GOLD FOIL - ONE SURFACE	0.00	0.00	0.00	0.00		XXX
D2420		C	GOLD FOIL - TWO SURFACES	0.00	0.00	0.00	0.00		XXX
D2430		C	GOLD FOIL - THREE SURFACES	0.00	0.00	0.00	0.00		XXX
D2510		C	INLAY - METALLIC - ONE SURFACE	0.00	0.00	0.00	0.00		XXX
D2520		C	INLAY - METALLIC - TWO SURFACES	0.00	0.00	0.00	0.00		XXX
D2530		C	INLAY - METALLIC - THREE SURFACES	0.00	0.00	0.00	0.00		XXX
D2540		C	ONLAY - METALLIC - PER TOOTH	0.00	0.00	0.00	0.00		XXX
D2610		C	INLAY - PORCELAIN/CERAMIC	0.00	0.00	0.00	0.00		XXX
D2620		C	INLAY - PORCELAIN/CERAMIC	0.00	0.00	0.00	0.00		XXX
D2630		C	INLAY - PORCELAIN/CERAMIC	0.00	0.00	0.00	0.00		XXX
D2640		C	ONLAY-PORCELAIN/CERAMIC	0.00	0.00	0.00	0.00		XXX
D2650		C	INLAY-COMPOSITE/RESIN ONE SURFACE	0.00	0.00	0.00	0.00		XXX
D2651		C	INLAY-COMPOSITE/RESIN 2 SURFACES	0.00	0.00	0.00	0.00		XXX
D2652		C	INLAY-COMPOSITE/RESIN 3 SURFACES	0.00	0.00	0.00	0.00		XXX
D2660		C	ONLAY-COMPOSITE/RESIN	0.00	0.00	0.00	0.00		XXX
D2710		C	CROWN-RESIN (LABORATORY)	0.00	0.00	0.00	0.00		XXX
D2720		C	CROWN-RESIN - HIGH NOBLE METAL	0.00	0.00	0.00	0.00		XXX
D2721		C	CROWN-RESIN - PREDOM BASE METAL	0.00	0.00	0.00	0.00		XXX
D2722		C	CROWN-RESIN WITH NOBLE METAL	0.00	0.00	0.00	0.00		XXX
D2740		C	CROWN-PORCELAIN/CERAMIC SUBSTRATE	0.00	0.00	0.00	0.00		XXX
D2750		C	CROWN-PORCELAIN FUSED - METAL	0.00	0.00	0.00	0.00		XXX
D2751		C	CROWN-PORCELAIN FUSED - METAL	0.00	0.00	0.00	0.00		XXX
D2752		C	CROWN-PORCELAIN FUSED - METAL	0.00	0.00	0.00	0.00		XXX
D2790		C	CROWN -FULL CAST HIGH NOBLE METAL	0.00	0.00	0.00	0.00		XXX
D2791		C	CROWN -FULL CAST PREDOM BASE METAL	0.00	0.00	0.00	0.00		XXX
D2792		C	CROWN -FULL CAST NOBLE METAL	0.00	0.00	0.00	0.00		XXX
D2810		C	CROWN - 3/4 CAST METALLIC	0.00	0.00	0.00	0.00		XXX
D2910		C	RECEMENT INLAY	0.00	0.00	0.00	0.00		XXX
D2920		C	RECEMENT CROWN	0.00	0.00	0.00	0.00		XXX
D2930		C	PREFAB STAINLESS STEEL CROWN	0.00	0.00	0.00	0.00		XXX
D2931		C	PREFAB STAINLESS STEEL CROWN	0.00	0.00	0.00	0.00		XXX
D2932		C	PREFABRICATED RESIN CROWN	0.00	0.00	0.00	0.00		XXX
D2933		C	PREFAB STAINLESS STEEL CROWN	0.00	0.00	0.00	0.00		XXX
D2940		C	SEDATIVE FILLING	0.00	0.00	0.00	0.00		XXX
D2950		C	CROWN BUILD-UP, INCLUDING ANY PINS	0.00	0.00	0.00	0.00		XXX
D2951		C	PIN RETENTION - PER TOOTH	0.00	0.00	0.00	0.00		XXX
D2952		C	CAST POST AND CORE	0.00	0.00	0.00	0.00		XXX
D2953		D	CAST POST AS PART OF CROWN	0.00	0.00	0.00	0.00		XXX
D2954		C	PREFAB POST AND CORE	0.00	0.00	0.00	0.00		XXX
D2960		C	LABIAL VENEER (LAMINATE)	0.00	0.00	0.00	0.00		XXX
D2970		C	TEMPORARY (FRACTURED TOOTH)	0.00	0.00	0.00	0.00		XXX
D2980		C	CROWN REPAIR, BY REPORT	0.00	0.00	0.00	0.00		XXX
D2999		C	UNSPECIFIED RESTORATIVE PROCEDURE	0.00	0.00	0.00	0.00		XXX
D3110		C	PULP CAP - DIRECT	0.00	0.00	0.00	0.00		XXX
D3120		C	PULP CAP - INDIRECT	0.00	0.00	0.00	0.00		XXX
D3220		C	THERAPEUTIC PULPOTOMY	0.00	0.00	0.00	0.00		XXX
D3310		C	ONE CANAL	0.00	0.00	0.00	0.00		XXX
D3320		C	TWO CANALS	0.00	0.00	0.00	0.00		XXX
D3330		C	THREE CANALS	0.00	0.00	0.00	0.00		XXX
D3340		D	FOUR OR MORE CANALS	0.00	0.00	0.00	0.00		XXX
D3346		C	RETREATMENT-ANTERIOR	0.00	0.00	0.00	0.00		XXX
D3347		C	RETREATMENT-BICUSPID	0.00	0.00	0.00	0.00		XXX

ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
D3348		C	RETREATMENT-MOLAR	0.00	0.00	0.00	0.00		XXX
D3350		D	APEXIFICATION -PER TREATMENT VISIT	0.00	0.00	0.00	0.00		XXX
D3351		C	APEXIFICATION/RECALCIFICATION	0.00	0.00	0.00	0.00		XXX
D3352		C	APEXIFICATION/RECALCIFICATION	0.00	0.00	0.00	0.00		XXX
D3353		C	APEXIFICATION/RECALCIFICATION	0.00	0.00	0.00	0.00		XXX
D3410		C	APICOECTOMY (PER TOOTH)	0.00	0.00	0.00	0.00		XXX
D3411		D	APICOECTOMY (PER TOOTH)	0.00	0.00	0.00	0.00		XXX
D3421		C	APICOECTOMY/PERIRADICULAR	0.00	0.00	0.00	0.00		XXX
D3425		C	APICOECTOMY/PERIRADICULAR	0.00	0.00	0.00	0.00		XXX
D3426		C	APICOECTOMY/PERIRADICULAR SURGERY	0.00	0.00	0.00	0.00		XXX
D3430		C	RETROGRADE FILLING - PER ROOT	0.00	0.00	0.00	0.00		XXX
D3440		D	APICAL CURETTAGE	0.00	0.00	0.00	0.00		XXX
D3450		C	ROOT AMPUTATION - PER ROOT	0.00	0.00	0.00	0.00		XXX
D3460		C	ENDODONTIC ENDOSSEOUS IMPLANT	0.00	0.00	0.00	0.00		XXX
D3470		C	INTENTIONAL REPLANTATION	0.00	0.00	0.00	0.00		XXX
D3910		C	SURGICAL PROCEDURE FOR ISOLATION	0.00	0.00	0.00	0.00		XXX
D3920		C	HEMISECTION	0.00	0.00	0.00	0.00		XXX
D3940		D	RECALCIFICATION OR REPAIR	0.00	0.00	0.00	0.00		XXX
D3950		C	CANAL PREPARATION AND FITTING	0.00	0.00	0.00	0.00		XXX
D3960		C	BLEACHING OF DISCOLORED TOOTH	0.00	0.00	0.00	0.00		XXX
D3999		C	UNSPECIFIED ENDODONTIC PROCEDURE	0.00	0.00	0.00	0.00		XXX
D4210		C	GINGIVECTOMY OR GINGIVOPLASTY	0.00	0.00	0.00	0.00		XXX
D4211		C	GINGIVECTOMY OR GINGIVOPLASTY	0.00	0.00	0.00	0.00		XXX
D4220		C	GINGIVAL CURETTAGE, BY REPORT	0.00	0.00	0.00	0.00		XXX
D4240		C	GINGIVAL FLAP PROCEDURE	0.00	0.00	0.00	0.00		XXX
D4249		C	CROWN LENGTHENING	0.00	0.00	0.00	0.00		XXX
D4250		C	MUCOGINGIVAL SURGERY-PER QUADRANT	0.00	0.00	0.00	0.00		XXX
D4260		C	OSSEOUS SURGERY	0.00	0.00	0.00	0.00		XXX
D4261		C	OSSEOUS GRAFT - SINGLE SITE	0.00	0.00	0.00	0.00		XXX
D4262		C	OSSEOUS GRAFT - MULTIPLE SITES	0.00	0.00	0.00	0.00		XXX
D4268		C	GUIDED TISSUE REGENERATION	0.00	0.00	0.00	0.00		XXX
D4270		C	PEDICLE SOFT TISSUE GRAFT	0.00	0.00	0.00	0.00		XXX
D4271		C	FREE SOFT TISSUE GRAFT	0.00	0.00	0.00	0.00		XXX
D4272		D	APICALLY REPOSITIONING FLAP	0.00	0.00	0.00	0.00		XXX
D4320		C	PROVISIONAL SPLINTING - INTRA	0.00	0.00	0.00	0.00		XXX
D4321		C	PROVISIONAL SPLINTING - EXTRA	0.00	0.00	0.00	0.00		XXX
D4340		D	PERIODONTAL SCALING	0.00	0.00	0.00	0.00		XXX
D4341		C	PERIODONTAL SCALING	0.00	0.00	0.00	0.00		XXX
D4910		C	PERIODONTAL MAINTENANCE	0.00	0.00	0.00	0.00		XXX
D4920		C	UNSCHEDULED DRESSING CHANGE	0.00	0.00	0.00	0.00		XXX
D4999		C	UNSPECIFIED PERIODONTAL PROCEDURE	0.00	0.00	0.00	0.00		XXX
D5110		C	COMPLETE UPPER	0.00	0.00	0.00	0.00		XXX
D5120		C	COMPLETE LOWER	0.00	0.00	0.00	0.00		XXX
D5130		C	IMMEDIATE UPPER	0.00	0.00	0.00	0.00		XXX
D5140		C	IMMEDIATE LOWER	0.00	0.00	0.00	0.00		XXX
D5211		C	UPPER PARTIAL - ACRYLIC BASE	0.00	0.00	0.00	0.00		XXX
D5212		C	LOWER PARTIAL - ACRYLIC BASE	0.00	0.00	0.00	0.00		XXX
D5213		C	UPPER PARTIAL	0.00	0.00	0.00	0.00		XXX
D5214		C	LOWER PARTIAL	0.00	0.00	0.00	0.00		XXX
D5215		D	UPPER PARTIAL - HIGH NOBLE CAST	0.00	0.00	0.00	0.00		XXX
D5216		D	LOWER PARTIAL - HIGH NOBLE CAST	0.00	0.00	0.00	0.00		XXX
D5280		D	REMOVABLE UNILATERAL PARTIAL	0.00	0.00	0.00	0.00		XXX
D5281		C	REMOVABLE UNILATERAL PARTIAL	0.00	0.00	0.00	0.00		XXX
D5410		C	ADJUST COMPLETE DENTURE-UPPER	0.00	0.00	0.00	0.00		XXX
D5411		C	ADJUST COMPLETE DENTURE - LOWER	0.00	0.00	0.00	0.00		XXX
D5421		C	ADJUST PARTIAL DENTURE - UPPER	0.00	0.00	0.00	0.00		XXX
D5422		C	ADJUST PARTIAL DENTURE - LOWER	0.00	0.00	0.00	0.00		XXX
D5510		C	REPAIR BROKEN COMPLETE DENTURE	0.00	0.00	0.00	0.00		XXX
D5520		C	REPLACE MISSING OR BROKEN TEETH	0.00	0.00	0.00	0.00		XXX
D5610		C	REPAIR ACRYLIC SADDLE OR BASE	0.00	0.00	0.00	0.00		XXX
D5620		C	REPAIR CAST FRAMEWORK	0.00	0.00	0.00	0.00		XXX
D5630		C	REPAIR OR REPLACE BROKEN CLASP	0.00	0.00	0.00	0.00		XXX
D5640		C	REPLACE BROKEN TEETH - PER TOOTH	0.00	0.00	0.00	0.00		XXX
D5650		C	ADD TOOTH TO EXISTING PARTIAL	0.00	0.00	0.00	0.00		XXX
D5660		C	ADD CLASP TO EXISTING PARTIAL	0.00	0.00	0.00	0.00		XXX
D5710		C	REBASE COMPLETE UPPER DENTURE	0.00	0.00	0.00	0.00		XXX
D5711		C	REBASE COMPLETE LOWER DENTURE	0.00	0.00	0.00	0.00		XXX
D5720		C	REBASE UPPER PARTIAL DENTURE	0.00	0.00	0.00	0.00		XXX
D5721		C	REBASE LOWER PARTIAL DENTURE	0.00	0.00	0.00	0.00		XXX

ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
D5730		C	RELINE UPPER COMPLETE DENTURE	0.00	0.00	0.00	0.00		XXX
D5731		C	RELINE LOWER COMPLETE DENTURE	0.00	0.00	0.00	0.00		XXX
D5740		C	RELINE UPPER PARTIAL DENTURE	0.00	0.00	0.00	0.00		XXX
D5741		C	RELINE LOWER PARTIAL DENTURE	0.00	0.00	0.00	0.00		XXX
D5750		C	RELINE UPPER COMPLETE DENTURE	0.00	0.00	0.00	0.00		XXX
D5751		C	RELINE LOWER COMPLETE DENTURE	0.00	0.00	0.00	0.00		XXX
D5760		C	RELINE UPPER PARTIAL DENTURE	0.00	0.00	0.00	0.00		XXX
D5761		C	RELINE LOWER PARTIAL DENTURE	0.00	0.00	0.00	0.00		XXX
D5810		C	TEMPORARY COMPLETE DENTURE (UPPER)	0.00	0.00	0.00	0.00		XXX
D5811		C	TEMPORARY COMPLETE DENTURE (LOWER)	0.00	0.00	0.00	0.00		XXX
D5820		C	TEMPORARY PARTIAL - STAYPLATE	0.00	0.00	0.00	0.00		XXX
D5821		C	TEMPORARY PARTIAL - STAYPLATE	0.00	0.00	0.00	0.00		XXX
D5850		C	TISSUE CONDITIONING - PER DENTURE	0.00	0.00	0.00	0.00		XXX
D5851		C	TISSUE CONDITIONING	0.00	0.00	0.00	0.00		XXX
D5860		C	OVERDENTURE - COMPLETE, BY REPORT	0.00	0.00	0.00	0.00		XXX
D5861		C	OVERDENTURE - PARTIAL, BY REPORT	0.00	0.00	0.00	0.00		XXX
D5862		C	PRECISION ATTACHMENT, BY REPORT	0.00	0.00	0.00	0.00		XXX
D5899		C	UNSPECIFIED PROSTHOdontIC PROCED	0.00	0.00	0.00	0.00		XXX
D5911		C	FACIAL MOULAGE (SECTIONAL)	0.00	0.00	0.00	0.00		XXX
D5912		C	FACIAL MOULAGE (COMPLETE)	0.00	0.00	0.00	0.00		XXX
D5913		C	NASAL PROSTHESIS	0.00	0.00	0.00	0.00		XXX
D5914		C	AURICULAR PROSTHESIS	0.00	0.00	0.00	0.00		XXX
D5915		C	ORBITAL PROSTHESIS	0.00	0.00	0.00	0.00		XXX
D5916		C	OCULAR PROSTHESIS	0.00	0.00	0.00	0.00		XXX
D5917		D	COMPOSITE FACIAL PROSTHESIS	0.00	0.00	0.00	0.00		XXX
D5918		D	REPLACEMENT PROSTHESIS	0.00	0.00	0.00	0.00		XXX
D5919		C	PROSTHETIC DRESSING	0.00	0.00	0.00	0.00		XXX
D5920		D	OCULAR IMPLANT	0.00	0.00	0.00	0.00		XXX
D5921		D	ORBITAL IMPLANT	0.00	0.00	0.00	0.00		XXX
D5922		C	NASAL SEPTAL PROSTHESIS	0.00	0.00	0.00	0.00		XXX
D5923		C	OCULAR PROSTHESIS	0.00	0.00	0.00	0.00		XXX
D5924		C	CRANIAL PROSTHESIS	0.00	0.00	0.00	0.00		XXX
D5925		C	FACIAL AUGMENTATION	0.00	0.00	0.00	0.00		XXX
D5926		C	NASAL PROSTHESIS, REPLACEMENT	0.00	0.00	0.00	0.00		XXX
D5927		C	AURICULAR PROSTHESIS, REPLACEMENT	0.00	0.00	0.00	0.00		XXX
D5928		C	ORBITAL PROSTHESIS, REPLACEMENT	0.00	0.00	0.00	0.00		XXX
D5929		C	FACIAL PROSTHESIS, REPLACEMENT	0.00	0.00	0.00	0.00		XXX
D5931		C	SURGICAL OBTURATOR	0.00	0.00	0.00	0.00		XXX
D5932		C	POSTSURGICAL OBTURATOR	0.00	0.00	0.00	0.00		XXX
D5933		C	REFITTING OF OBTURATOR	0.00	0.00	0.00	0.00		XXX
D5934		C	MANDIBULAR RESECTION PROSTHESIS	0.00	0.00	0.00	0.00		XXX
D5935		C	MANDIBULAR RESECTION PROSTHESIS	0.00	0.00	0.00	0.00		XXX
D5936		C	OBTURATOR PROSTHESIS, INTERIM	0.00	0.00	0.00	0.00		XXX
D5937		C	TRISMUS APPLIANCE	0.00	0.00	0.00	0.00		XXX
D5951		C	FEEDING AID	0.00	0.00	0.00	0.00		XXX
D5952		C	PEDIATRIC SPEECH AID	0.00	0.00	0.00	0.00		XXX
D5953		C	ADULT SPEECH AID	0.00	0.00	0.00	0.00		XXX
D5954		C	SUPERIMPOSED PROSTHESIS	0.00	0.00	0.00	0.00		XXX
D5955		C	PALATAL LIFT PROSTHESIS	0.00	0.00	0.00	0.00		XXX
D5956		D	OBTURATOR	0.00	0.00	0.00	0.00		XXX
D5957		D	SPEECH BULB	0.00	0.00	0.00	0.00		XXX
D5958		C	PALATAL LIFT PROSTHESIS, INTERIM	0.00	0.00	0.00	0.00		XXX
D5959		C	PALATAL LIFT PROSTHESIS, MOD	0.00	0.00	0.00	0.00		XXX
D5960		C	SPEECH AID PROSTHESIS, MOD	0.00	0.00	0.00	0.00		XXX
D5971		D	SIMPLE IMPLANT	0.00	0.00	0.00	0.00		XXX
D5972		D	COMPLEX IMPLANT	0.00	0.00	0.00	0.00		XXX
D5973		D	SUBPERIOSTEAL IMPLANT	0.00	0.00	0.00	0.00		XXX
D5974		D	ENDOSSEOUS IMPLANT (IN THE BONE)	0.00	0.00	0.00	0.00		XXX
D5976		D	MANDIBULAR STAPLE IMPLANT	0.00	0.00	0.00	0.00		XXX
D5982		C	SURGICAL STENT	0.00	0.00	0.00	0.00		XXX
D5983		C	RADIATION CARRIER	0.00	0.00	0.00	0.00		XXX
D5984		C	RADIATION SHIELD	0.00	0.00	0.00	0.00		XXX
D5985		C	DOCKING DEVICE-CONE LOCATOR	0.00	0.00	0.00	0.00		XXX
D5986		C	FLUORIDE APPLICATOR-PER ARCH	0.00	0.00	0.00	0.00		XXX
D5988		C	SURGICAL SPLINT	0.00	0.00	0.00	0.00		XXX
D5999		C	UNSPECIFIED MAXILLOFAC PROSTHESIS	0.00	0.00	0.00	0.00		XXX
D6030		C	ENDOSSEOUS IMPLANT	0.00	0.00	0.00	0.00		XXX
D6040		C	SUBPERIOSTEAL IMPLANT	0.00	0.00	0.00	0.00		XXX
D6050		C	TRANSOSSEOUS IMPLANT	0.00	0.00	0.00	0.00		XXX

ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
D6055		C	IMPLANT CONNECTING BAR	0.00	0.00	0.00	0.00		XXX
D6080		C	IMPLANT MAINTENANCE PROCEDURES	0.00	0.00	0.00	0.00		XXX
D6090		C	REPAIR IMPLANT	0.00	0.00	0.00	0.00		XXX
D6100		C	IMPLANT REMOVAL	0.00	0.00	0.00	0.00		XXX
D6199		C	UNSPECIFIED IMPLANT PROCEDURE	0.00	0.00	0.00	0.00		XXX
D6210		C	PONTIC - CAST HIGH NOBLE METAL	0.00	0.00	0.00	0.00		XXX
D6211		C	PONTIC - CAST PREDOM BASE METAL	0.00	0.00	0.00	0.00		XXX
D6212		C	PONTIC - CAST NOBLE METAL	0.00	0.00	0.00	0.00		XXX
D6240		C	PONTIC - PORCELAIN FUSED	0.00	0.00	0.00	0.00		XXX
D6241		C	PONTIC - PORCELAIN FUSED	0.00	0.00	0.00	0.00		XXX
D6242		C	PONTIC - PORCELAIN FUSED	0.00	0.00	0.00	0.00		XXX
D6250		C	PONTIC-RESIN WITH HIGH NOBLE METAL	0.00	0.00	0.00	0.00		XXX
D6251		C	PONTIC - RESIN WITH -BASE METAL	0.00	0.00	0.00	0.00		XXX
D6252		C	PONTIC - RESIN WITH NOBLE METAL	0.00	0.00	0.00	0.00		XXX
D6520		C	INLAY - METALLIC - TWO SURFACES	0.00	0.00	0.00	0.00		XXX
D6530		C	INLAY - METALLIC - THREE OR MORE	0.00	0.00	0.00	0.00		XXX
D6540		C	INLAY - METALLIC ONLAYING CUSPS	0.00	0.00	0.00	0.00		XXX
D6545		C	CAST METAL RETAINER FOR ACID ETCH	0.00	0.00	0.00	0.00		XXX
D6720		C	CROWN - RESIN WITH HIGH NOBLE METAL	0.00	0.00	0.00	0.00		XXX
D6721		C	CROWN - RESIN WITH - BASE METAL	0.00	0.00	0.00	0.00		XXX
D6722		C	CROWN - RESIN WITH NOBLE METAL	0.00	0.00	0.00	0.00		XXX
D6750		C	CROWN - PORCELAIN FUSED	0.00	0.00	0.00	0.00		XXX
D6751		C	CROWN - PORCELAIN FUSED	0.00	0.00	0.00	0.00		XXX
D6752		C	CROWN - PORCELAIN FUSED	0.00	0.00	0.00	0.00		XXX
D6780		C	CROWN - 3/4 CAST HIGH NOBLE METAL	0.00	0.00	0.00	0.00		XXX
D6790		C	CROWN - FULL CAST HIGH NOBLE METAL	0.00	0.00	0.00	0.00		XXX
D6791		C	CROWN - FULL CAST - BASE METAL	0.00	0.00	0.00	0.00		XXX
D6792		C	CROWN - FULL CAST NOBLE METAL	0.00	0.00	0.00	0.00		XXX
D6930		C	RECEMENT BRIDGE	0.00	0.00	0.00	0.00		XXX
D6940		C	STRESS BREAKER	0.00	0.00	0.00	0.00		XXX
D6950		C	PRECISION ATTACHMENT	0.00	0.00	0.00	0.00		XXX
D6970		C	CAST POST AND CORE	0.00	0.00	0.00	0.00		XXX
D6971		C	CAST POST -PART OF BRIDGE RETAINER	0.00	0.00	0.00	0.00		XXX
D6972		C	PREFABRICATED POST AND CORE	0.00	0.00	0.00	0.00		XXX
D6973		C	CORE BUILD UP FOR RETAINER	0.00	0.00	0.00	0.00		XXX
D6975		C	COPING-METAL	0.00	0.00	0.00	0.00		XXX
D6980		C	BRIDGE REPAIR, BY REPORT	0.00	0.00	0.00	0.00		XXX
D6999		C	UNSPECIFIED FIXED PROSTHODONTIC	0.00	0.00	0.00	0.00		XXX
D7110		C	SINGLE TOOTH	0.00	0.00	0.00	0.00		XXX
D7120		C	EACH ADDITIONAL TOOTH	0.00	0.00	0.00	0.00		XXX
D7130		C	ROOT REMOVAL - EXPOSED ROOTS	0.00	0.00	0.00	0.00		XXX
D7210		C	SURGICAL REMOVAL OF ERUPTED TOOTH	0.00	0.00	0.00	0.00		XXX
D7220		C	REMOVAL OF IMPACTED TOOTH	0.00	0.00	0.00	0.00		XXX
D7230		C	REMOVAL OF IMPACTED TOOTH	0.00	0.00	0.00	0.00		XXX
D7240		C	REMOVAL OF IMPACTED TOOTH	0.00	0.00	0.00	0.00		XXX
D7241		C	REMOVAL OF IMPACTED TOOTH	0.00	0.00	0.00	0.00		XXX
D7250		C	SURGICAL REMOVAL OF TOOTH ROOTS	0.00	0.00	0.00	0.00		XXX
D7260		C	OROANTRAL FISTULA CLOSURE	0.00	0.00	0.00	0.00		XXX
D7270		C	TOOTH RE-IMPLANTATION	0.00	0.00	0.00	0.00		XXX
D7271		C	TOOTH IMPLANTATION	0.00	0.00	0.00	0.00		XXX
D7272		C	TOOTH TRANSPLANTATION	0.00	0.00	0.00	0.00		XXX
D7280		C	SURG EXPOSURE OF IMPACTED TOOTH	0.00	0.00	0.00	0.00		XXX
D7281		C	SURG EXPOSURE OF IMPACTED TOOTH	0.00	0.00	0.00	0.00		XXX
D7285		C	BIOPSY OF ORAL TISSUE - HARD	0.00	0.00	0.00	0.00		XXX
D7286		C	BIOPSY OF ORAL TISSUE - SOFT	0.00	0.00	0.00	0.00		XXX
D7290		C	SURGICAL REPOSITIONING OF TEETH	0.00	0.00	0.00	0.00		XXX
D7291		C	TRANSSEPTAL FIBEROTOMY	0.00	0.00	0.00	0.00		XXX
D7310		C	ALVEOLOPLASTY	0.00	0.00	0.00	0.00		XXX
D7320		C	ALVEOLOPLASTY	0.00	0.00	0.00	0.00		XXX
D7340		C	VESTIBULOPLASTY	0.00	0.00	0.00	0.00		XXX
D7350		C	VESTIBULOPLASTY	0.00	0.00	0.00	0.00		XXX
D7410		C	RADICAL EXCISION	0.00	0.00	0.00	0.00		XXX
D7420		C	RADICAL EXCISION	0.00	0.00	0.00	0.00		XXX
D7430		C	EXCISION OF BENIGN TUMOR	0.00	0.00	0.00	0.00		XXX
D7431		C	EXCISION OF BENIGN TUMOR	0.00	0.00	0.00	0.00		XXX
D7440		C	EXCISION OF MALIGNANT TUMOR	0.00	0.00	0.00	0.00		XXX
D7441		C	EXCISION OF MALIGNANT TUMOR	0.00	0.00	0.00	0.00		XXX
D7450		C	REMOVAL OF ODONTOGENIC CYST	0.00	0.00	0.00	0.00		XXX
D7451		C	REMOVAL OF ODONTOGENIC CYST	0.00	0.00	0.00	0.00		XXX

ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
D7460		C	REMOVAL OF NONODONTOGENIC CYST	0.00	0.00	0.00	0.00		XXX
D7461		C	REMOVAL OF NONODONTOGENIC CYST	0.00	0.00	0.00	0.00		XXX
D7465		C	DESTRUCTION OF LESION(S)	0.00	0.00	0.00	0.00		XXX
D7470		C	REMOVAL OF EXOSTOSIS	0.00	0.00	0.00	0.00		XXX
D7480		C	PARTIAL OSTECTOMY	0.00	0.00	0.00	0.00		XXX
D7490		C	RADICAL RESECTION OF MANDIBLE	0.00	0.00	0.00	0.00		XXX
D7510		C	INCISION AND DRAINAGE OF ABSCESS	0.00	0.00	0.00	0.00		XXX
D7520		C	INCISION AND DRAINAGE OF ABSCESS	0.00	0.00	0.00	0.00		XXX
D7530		C	REMOVAL OF FOREIGN BODY, SKIN	0.00	0.00	0.00	0.00		XXX
D7540		C	REMOVAL OF FOREIGN BODIES	0.00	0.00	0.00	0.00		XXX
D7550		C	SEQUESTRECTOMY FOR OSTEOMYELITIS	0.00	0.00	0.00	0.00		XXX
D7560		C	MAXILLARY SINUSOTOMY	0.00	0.00	0.00	0.00		XXX
D7610		C	MAXILLA - OPEN REDUCTION	0.00	0.00	0.00	0.00		XXX
D7620		C	MAXILLA - CLOSED REDUCTION	0.00	0.00	0.00	0.00		XXX
D7630		C	MANDIBLE - OPEN REDUCTION	0.00	0.00	0.00	0.00		XXX
D7640		C	MANDIBLE - CLOSED REDUCTION	0.00	0.00	0.00	0.00		XXX
D7650		C	MALAR AND/OR ZYGOMATIC ARCH	0.00	0.00	0.00	0.00		XXX
D7660		C	MALAR AND/OR ZYGOMATIC ARCH	0.00	0.00	0.00	0.00		XXX
D7670		C	ALVEOLUS - STABILIZATION OF TEETH	0.00	0.00	0.00	0.00		XXX
D7680		C	FACIAL BONES - COMPLICATED REDUCT	0.00	0.00	0.00	0.00		XXX
D7710		C	MAXILLA - OPEN REDUCTION	0.00	0.00	0.00	0.00		XXX
D7720		C	MAXILLA - CLOSED REDUCTION	0.00	0.00	0.00	0.00		XXX
D7730		C	MANDIBLE - OPEN REDUCTION	0.00	0.00	0.00	0.00		XXX
D7740		C	MANDIBLE - CLOSED REDUCTION	0.00	0.00	0.00	0.00		XXX
D7750		C	MALAR AND/OR ZYGOMATIC ARCH	0.00	0.00	0.00	0.00		XXX
D7760		C	MALAR AND/OR ZYGOMATIC ARCH	0.00	0.00	0.00	0.00		XXX
D7770		C	ALVEOLUS - STABILIZATION OF TEETH	0.00	0.00	0.00	0.00		XXX
D7780		C	FACIAL BONES - COMPLICATED REDUCT	0.00	0.00	0.00	0.00		XXX
D7810		C	OPEN REDUCTION OF DISLOCATION	0.00	0.00	0.00	0.00		XXX
D7820		C	CLOSED REDUCTION OF DISLOCATION	0.00	0.00	0.00	0.00		XXX
D7830		C	MANIPULATION UNDER ANESTHESIA	0.00	0.00	0.00	0.00		XXX
D7840		C	CONDYLECTOMY	0.00	0.00	0.00	0.00		XXX
D7850		C	MENISECTOMY	0.00	0.00	0.00	0.00		XXX
D7852		C	DISC REPAIR	0.00	0.00	0.00	0.00		XXX
D7854		C	SYNOVECTOMY	0.00	0.00	0.00	0.00		XXX
D7856		C	MYOTOMY	0.00	0.00	0.00	0.00		XXX
D7858		C	JOINT RECONSTRUCTION	0.00	0.00	0.00	0.00		XXX
D7860		C	ARTHROTOMY	0.00	0.00	0.00	0.00		XXX
D7865		C	ARTHROPLASTY	0.00	0.00	0.00	0.00		XXX
D7870		C	ARTHROCENTESIS	0.00	0.00	0.00	0.00		XXX
D7872		C	ARTHROSCOPY-DIAGNOSIS	0.00	0.00	0.00	0.00		XXX
D7873		C	ARTHROSCOPY-SURGICAL	0.00	0.00	0.00	0.00		XXX
D7874		C	ARTHROSCOPY-SURGICAL	0.00	0.00	0.00	0.00		XXX
D7875		C	ARTHROSCOPY-SURGICAL	0.00	0.00	0.00	0.00		XXX
D7876		C	ARTHROSCOPY-SURGICAL	0.00	0.00	0.00	0.00		XXX
D7877		C	ARTHROSCOPY-SURGICAL	0.00	0.00	0.00	0.00		XXX
D7880		C	OCCCLUSAL ORTHOTIC APPLIANCE	0.00	0.00	0.00	0.00		XXX
D7899		C	UNSPECIFIED TMD THERAPY	0.00	0.00	0.00	0.00		XXX
D7910		C	SUTURE OF RECENT SMALL WOUNDS	0.00	0.00	0.00	0.00		XXX
D7911		C	SUTURE - UP TO 5 CM	0.00	0.00	0.00	0.00		XXX
D7912		C	SUTURE - OVER 5 CM	0.00	0.00	0.00	0.00		XXX
D7920		C	SKIN GRAFTS	0.00	0.00	0.00	0.00		XXX
D7940		C	OSTEOPLASTY	0.00	0.00	0.00	0.00		XXX
D7941		C	OSTEOTOMY - RAMUS, CLOSED	0.00	0.00	0.00	0.00		XXX
D7942		C	OSTEOTOMY - RAMUS, OPEN	0.00	0.00	0.00	0.00		XXX
D7943		C	OSTEOTOMY - RAMUS, OPEN	0.00	0.00	0.00	0.00		XXX
D7944		C	OSTEOTOMY - SEGMENTED OR SUBAPICAL	0.00	0.00	0.00	0.00		XXX
D7945		C	OSTEOTOMY - BODY OF MANDIBLE	0.00	0.00	0.00	0.00		XXX
D7946		C	LEFORT I (MAXILLA - TOTAL)	0.00	0.00	0.00	0.00		XXX
D7947		C	LEFORT I (MAXILLA - SEGMENTED)	0.00	0.00	0.00	0.00		XXX
D7948		C	LEFORT II OR LEFORT III	0.00	0.00	0.00	0.00		XXX
D7949		C	LEFORT II OR LEFORT III	0.00	0.00	0.00	0.00		XXX
D7950		C	OSSEOUS, OSTEOPERIOSTEAL GRAFT	0.00	0.00	0.00	0.00		XXX
D7955		C	REPAIR OF MAXILLOFACIAL DEFECTS	0.00	0.00	0.00	0.00		XXX
D7960		C	FRENULECTOMY - SEPARATE PROCEDURE	0.00	0.00	0.00	0.00		XXX
D7970		C	EXCISION OF HYPERPLASTIC TISSUE	0.00	0.00	0.00	0.00		XXX
D7971		C	EXCISION OF PERICORONAL GINGIVA	0.00	0.00	0.00	0.00		XXX
D7980		C	SIALOLITHOTOMY	0.00	0.00	0.00	0.00		XXX
D7981		C	EXCISION OF SALIVARY GLAND	0.00	0.00	0.00	0.00		XXX

ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
D7982		C	SIALODOCHOPLASTY	0.00	0.00	0.00	0.00		XXX
D7983		C	CLOSURE OF SALIVARY FISTULA	0.00	0.00	0.00	0.00		XXX
D7990		C	EMERGENCY TRACHEOTOMY	0.00	0.00	0.00	0.00		XXX
D7991		C	CORONOIDECTOMY	0.00	0.00	0.00	0.00		XXX
D7992		D	EMINENECTOMY	0.00	0.00	0.00	0.00		XXX
D7993		C	IMPLANT - FACIAL BONES	0.00	0.00	0.00	0.00		XXX
D7994		C	IMPLANT - CHIN	0.00	0.00	0.00	0.00		XXX
D7999		C	UNSPECIFIED ORAL SURGERY PROCEDURE	0.00	0.00	0.00	0.00		XXX
D8110		C	REMOVABLE APPLIANCE THERAPY	0.00	0.00	0.00	0.00		XXX
D8120		C	FIXED APPLIANCE THERAPY	0.00	0.00	0.00	0.00		XXX
D8210		C	REMOVABLE APPLIANCE THERAPY	0.00	0.00	0.00	0.00		XXX
D8220		C	FIXED APPLIANCE THERAPY	0.00	0.00	0.00	0.00		XXX
D8360		C	REMOVABLE APPLIANCE THERAPY	0.00	0.00	0.00	0.00		XXX
D8370		C	FIXED APPLIANCE THERAPY	0.00	0.00	0.00	0.00		XXX
D8460		C	CLASS I MALOCCLUSION	0.00	0.00	0.00	0.00		XXX
D8470		C	CLASS II MALOCCLUSION	0.00	0.00	0.00	0.00		XXX
D8480		C	CLASS III MALOCCLUSION	0.00	0.00	0.00	0.00		XXX
D8560		C	CLASS I MALOCCLUSION	0.00	0.00	0.00	0.00		XXX
D8570		C	CLASS II MALOCCLUSION	0.00	0.00	0.00	0.00		XXX
D8580		C	CLASS III MALOCCLUSION	0.00	0.00	0.00	0.00		XXX
D8650		C	TREATMENT OF SKELETAL CASE	0.00	0.00	0.00	0.00		XXX
D8750		C	POST-TREATMENT STABILIZATION	0.00	0.00	0.00	0.00		XXX
D8999		C	UNSPECIFIED ORTHODONTIC PROCEDURE	0.00	0.00	0.00	0.00		XXX
D9110		C	PALLIATIVE TREATMENT - DENTAL PAIN	0.00	0.00	0.00	0.00		XXX
D9210		C	LOCAL ANESTHESIA	0.00	0.00	0.00	0.00		XXX
D9211		C	REGIONAL BLOCK ANESTHESIA	0.00	0.00	0.00	0.00		XXX
D9212		C	TRIGEMINAL DIVISION BLOCK ANESTHES	0.00	0.00	0.00	0.00		XXX
D9215		C	LOCAL ANESTHESIA	0.00	0.00	0.00	0.00		XXX
D9220		C	GENERAL ANESTHESIA	0.00	0.00	0.00	0.00		XXX
D9230		C	ANALGESIA	0.00	0.00	0.00	0.00		XXX
D9240		C	INTRAVENOUS SEDATION	0.00	0.00	0.00	0.00		XXX
D9310		C	CONSULTATION - PER SESSION	0.00	0.00	0.00	0.00		XXX
D9410		C	HOUSE CALL	0.00	0.00	0.00	0.00		XXX
D9420		C	HOSPITAL CALL	0.00	0.00	0.00	0.00		XXX
D9430		C	OFFICE VISIT FOR OBSERVATION	0.00	0.00	0.00	0.00		XXX
D9440		C	OFFICE VISIT	0.00	0.00	0.00	0.00		XXX
D9610		C	THERAPEUTIC DRUG INJECTION	0.00	0.00	0.00	0.00		XXX
D9630		C	OTHER DRUGS AND/OR MEDICAMENTS	0.00	0.00	0.00	0.00		XXX
D9910		C	APPLICATION OF MEDICAMENTS	0.00	0.00	0.00	0.00		XXX
D9920		C	BEHAVIOR MANAGEMENT	0.00	0.00	0.00	0.00		XXX
D9930		C	TREATMENT OF COMPLICATIONS	0.00	0.00	0.00	0.00		XXX
D9940		C	OCCUSAL GUARDS	0.00	0.00	0.00	0.00		XXX
D9941		C	FABRICATION OF ATHLETIC MOUTHGUARD	0.00	0.00	0.00	0.00		XXX
D9950		C	OCCUSION ANALYSIS - MOUNTED CASE	0.00	0.00	0.00	0.00		XXX
D9951		C	OCCUSAL ADJUSTMENT - LIMITED	0.00	0.00	0.00	0.00		XXX
D9952		C	OCCUSAL ADJUSTMENT - COMPLETE	0.00	0.00	0.00	0.00		XXX
D9960		D	COMPLETION OF CLAIM FORM	0.00	0.00	0.00	0.00		XXX
D9999		C	UNSPECIFIED ADJUNCTIVE PROCEDURE	0.00	0.00	0.00	0.00		XXX
H5010		D	THERAPY, INDIVIDUAL	0.00	0.00	0.00	0.00		XXX
H5020		D	PSYCHOTHERAPY, GROUP	0.00	0.00	0.00	0.00		XXX
H5025		D	PSYCHOTHERAPY, GROUP	0.00	0.00	0.00	0.00		XXX
H5030		D	OTHER SERVICES BY SOCIAL WORKER	0.00	0.00	0.00	0.00		XXX
H5040		D	RESIDENTIAL CARE - PUBLIC INSTIT.	0.00	0.00	0.00	0.00		XXX
H5050		D	RESIDENTIAL CARE - PRIVATE INSTIT.	0.00	0.00	0.00	0.00		XXX
H5060		D	PUBLIC SPECIAL SCHOOLS OR DAY CARE	0.00	0.00	0.00	0.00		XXX
H5090		D	SPECIAL CLASS PRIVATE	0.00	0.00	0.00	0.00		XXX
H5100		D	SPECIAL CLASS PRIVATE PROPRIETARY	0.00	0.00	0.00	0.00		XXX
H5110		D	SUMMER TREATMENT CAMP	0.00	0.00	0.00	0.00		XXX
H5120		D	SPECIALIZED CARE NURSING HOME	0.00	0.00	0.00	0.00		XXX
H5130		D	VISITING TEACHER SERVICES	0.00	0.00	0.00	0.00		XXX
H5160		D	READING THERAPY	0.00	0.00	0.00	0.00		XXX
H5170		D	OTHER SPECIAL EDUCATION	0.00	0.00	0.00	0.00		XXX
H5180		D	TRANSPORTATION FOR HANDICAPPED	0.00	0.00	0.00	0.00		XXX
H5190		D	NURSING CARE, HOME	0.00	0.00	0.00	0.00		XXX
H5200		D	NURSING CARE, OTHER	0.00	0.00	0.00	0.00		XXX
H5220		V	REHABILITATIVE EVALUATION	0.00	0.00	0.00	0.00		XXX
H5230		V	REHABILITATIVE EVALUATION	0.00	0.00	0.00	0.00		XXX
H5240		V	REHABILITATIVE EVALUATION	0.00	0.00	0.00	0.00		XXX
H5299		D	REHABILITATIVE EVALUATION	0.00	0.00	0.00	0.00		XXX

ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS	MOD	STATUS	DESCRIPTION	WORK RVUS	PRACTICE EXPENSE RVUS	MAL- PRACTICE RVUS	TOTAL RVUS	SOURCE OF WORK RVUS	GLOBAL FEE PERIOD
H5300		A	OCCUPATIONAL THERAPY	0.33	0.25	0.03	0.61	3	XXX
J0110		E	ADMINISTRATION OF INJECTION	0.00	0.00	0.00	0.00		XXX
J0120		E	INJECTION, TETRACYCLINE	0.00	0.00	0.00	0.00		XXX
J0170		E	INJECTION, ADRENALIN, EPINEPHRINE	0.00	0.00	0.00	0.00		XXX
J0190		E	INJECTION, BIPERIDEN, 2 MG	0.00	0.00	0.00	0.00		XXX
J0210		E	INJECTION, METHYLDOPATE HCL	0.00	0.00	0.00	0.00		XXX
J0220		E	INJECTION, ALLERGY DESENSITIZATION	0.00	0.00	0.00	0.00		XXX
J0230		E	INJECTION, ALLERGY DESENSITIZATION	0.00	0.00	0.00	0.00		XXX
J0240		E	INJECTION, ALLERGY DESENSITIZATION	0.00	0.00	0.00	0.00		XXX
J0256		E	INJECTION, ALPHA 1-PROTEINASE INHI	0.00	0.00	0.00	0.00		XXX
J0280		E	INJECTION, AMINOPHYLLIN	0.00	0.00	0.00	0.00		XXX
J0290		E	INJECTION, AMPICILLIN	0.00	0.00	0.00	0.00		XXX
J0300		E	INJECTION, AMOBARBITAL	0.00	0.00	0.00	0.00		XXX
J0330		E	INJECTION, SUCCINYLCHOLINE CHLORIDE	0.00	0.00	0.00	0.00		XXX
J0340		E	INJECTION, NANDROLONE PHENPROPION.	0.00	0.00	0.00	0.00		XXX
J0360		E	INJECTION, HYDRALAZINE HCL	0.00	0.00	0.00	0.00		XXX
J0380		E	INJECTION, METARAMINOL	0.00	0.00	0.00	0.00		XXX
J0390		E	INJECTION, CHLOROQUINE	0.00	0.00	0.00	0.00		XXX
J0400		E	INJECTION, TRIMETHAPHAN	0.00	0.00	0.00	0.00		XXX
J0460		E	INJECTION, ATROPINE SULFATE	0.00	0.00	0.00	0.00		XXX
J0470		E	INJECTION, DIMECAPROL	0.00	0.00	0.00	0.00		XXX
J0500		E	INJECTION, DICYCLOMINE	0.00	0.00	0.00	0.00		XXX
J0510		E	INJECTION, BENZQUINAMIDE HCL	0.00	0.00	0.00	0.00		XXX
J0515		E	INJECTION, BENZTROPINE	0.00	0.00	0.00	0.00		XXX
J0520		E	INJECTION, BETHANECHOL CHLORIDE	0.00	0.00	0.00	0.00		XXX
J0530		E	INJECTION, PENICILLIN G BENZATHINE	0.00	0.00	0.00	0.00		XXX
J0540		E	INJECTION, PENICILLIN G BENZATHINE	0.00	0.00	0.00	0.00		XXX
J0550		E	INJECTION, PENICILLIN G BENZATHINE	0.00	0.00	0.00	0.00		XXX
J0560		E	INJECTION, PENICILLIN G BENZATHINE	0.00	0.00	0.00	0.00		XXX
J0570		E	INJECTION, PENICILLIN G BENZATHINE	0.00	0.00	0.00	0.00		XXX
J0580		E	INJECTION, PENICILLIN G BENZATHINE	0.00	0.00	0.00	0.00		XXX
J0585		E	BOTULINUM TOXIN TYPE A, PER UNIT	0.00	0.00	0.00	0.00		XXX
J0590		E	INJECTION, ETHYLNOREPINEPHRINE HCL	0.00	0.00	0.00	0.00		XXX
J0600		E	INJECTION, EDETATE CAL. DISODIUM	0.00	0.00	0.00	0.00		XXX
J0610		E	INJECTION, CALCIUM GLUCONATE	0.00	0.00	0.00	0.00		XXX
J0620		E	INJECTION, CALCIUM GLYCEROPHOS.	0.00	0.00	0.00	0.00		XXX
J0630		E	INJECTION, CALCITONIN SALMON	0.00	0.00	0.00	0.00		XXX
J0635		E	INJECTION, CALCITRIOL	0.00	0.00	0.00	0.00		XXX
J0640		E	INJECTION, LEUCOVORIN CALCIUM	0.00	0.00	0.00	0.00		XXX
J0670		E	INJECTION, MEPIVACAINE	0.00	0.00	0.00	0.00		XXX
J0680		E	INJECTION, DESLANOSIDE	0.00	0.00	0.00	0.00		XXX
J0690		E	INJECTION, CEFAZOLIN SODIUM	0.00	0.00	0.00	0.00		XXX
J0694		E	INJECTION, CEFOTITIN SODIUM	0.00	0.00	0.00	0.00		XXX
J0695		E	INJECTION, CEFONICID SODIUM	0.00	0.00	0.00	0.00		XXX
J0696		E	INJECTION, CEFTRIAXONE SODIUM	0.00	0.00	0.00	0.00		XXX
J0697		E	INJECTION, STERILE CEFUROXIME SO.	0.00	0.00	0.00	0.00		XXX
J0698		E	CEFOTAXIME SODIUM	0.00	0.00	0.00	0.00		XXX
J0700		E	INJECTION, BETAMETHASONE	0.00	0.00	0.00	0.00		XXX
J0710		E	INJECTION, CEPHAPIRIN SODIUM	0.00	0.00	0.00	0.00		XXX
J0720		E	INJECTION, CHLORAMPHENICOL SODIUM	0.00	0.00	0.00	0.00		XXX
J0725		E	INJECTION, CHORIONIC GONADOTROPIN	0.00	0.00	0.00	0.00		XXX
J0730		E	INJECTION, CHLORPHENIRAMINE MAL.	0.00	0.00	0.00	0.00		XXX
J0745		E	INJECTION, CODEINE PHOSPHATE	0.00	0.00	0.00	0.00		XXX
J0760		E	INJECTION, COLCHICINE	0.00	0.00	0.00	0.00		XXX
J0770		E	INJECTION, COLISTIMETHATE SODIUM	0.00	0.00	0.00	0.00		XXX
J0780		E	INJECTION, PROCHLORPERAZINE	0.00	0.00	0.00	0.00		XXX
J0790		E	INJECTION, NIKETHAMIDE	0.00	0.00	0.00	0.00		XXX
J0800		E	INJECTION, CORTICOTROPIN	0.00	0.00	0.00	0.00		XXX
J0810		E	INJECTION, CORTISONE	0.00	0.00	0.00	0.00		XXX
J0820		E	INJECTION, CORTIGEL 40	0.00	0.00	0.00	0.00		XXX
J0830		E	INJECTION, CORTROPHIN ZINC HYDROX.	0.00	0.00	0.00	0.00		XXX
J0840		E	INJECTION, WARFARIN SODIUM	0.00	0.00	0.00	0.00		XXX
J0895		E	INJECTION, DEFEROXAMINE MESYLATE	0.00	0.00	0.00	0.00		XXX
J0900		E	INJECTION, TESTOSTERONE ENANTHATE	0.00	0.00	0.00	0.00		XXX
J0945		E	INJECTION, BROMPHENIRAMINE MALEATE	0.00	0.00	0.00	0.00		XXX
J0970		E	INJECTION, ESTRADIOL VALERATE	0.00	0.00	0.00	0.00		XXX
J1000		E	INJECTION, DEPO-ESTRADIOL CYPIONAT	0.00	0.00	0.00	0.00		XXX
J1020		E	INJECTION, METHYLPREDNISOLONE	0.00	0.00	0.00	0.00		XXX
J1030		E	INJECTION, METHYLPREDNISOLONE	0.00	0.00	0.00	0.00		XXX

ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
J1040		E	INJECTION, METHYLPREDNISOLONE	0.00	0.00	0.00	0.00		XXX
J1050		E	INJECTION, MEDROXYPROGESTERONE	0.00	0.00	0.00	0.00		XXX
J1060		E	INJECTION, TESTOSTERONE CYPIONATE	0.00	0.00	0.00	0.00		XXX
J1070		E	INJECTION, TESTOSTERONE CYPIONATE	0.00	0.00	0.00	0.00		XXX
J1080		E	INJECTION, TESTOSTERONE CYPIONATE	0.00	0.00	0.00	0.00		XXX
J1090		E	INJECTION, TESTOSTERONE CYPIONATE	0.00	0.00	0.00	0.00		XXX
J1100		E	INJECTION, DEXAMETHOSONE SODIUM PH	0.00	0.00	0.00	0.00		XXX
J1110		E	INJECTION, DEHYDROERGOTAMINE	0.00	0.00	0.00	0.00		XXX
J1120		E	INJECTION, ACETAZOLAMIDE SODIUM	0.00	0.00	0.00	0.00		XXX
J1155		E	INJECTION, DIGITOXIN	0.00	0.00	0.00	0.00		XXX
J1160		E	INJECTION, DIGOXIN	0.00	0.00	0.00	0.00		XXX
J1165		E	INJECTION, PHENYTOIN SODIUM	0.00	0.00	0.00	0.00		XXX
J1170		E	INJECTION, HYDROMORPHONE	0.00	0.00	0.00	0.00		XXX
J1180		E	INJECTION, DYPHYLLINE	0.00	0.00	0.00	0.00		XXX
J1200		E	INJECTION, DIPHENHYDRAMINE HCL	0.00	0.00	0.00	0.00		XXX
J1205		E	INJECTION, CHLOROTHIAZIDE SODIUM	0.00	0.00	0.00	0.00		XXX
J1212		E	INJECTION, DMSO, DIMETHYL SULFX.	0.00	0.00	0.00	0.00		XXX
J1230		E	INJECTION, METHADONE HCL	0.00	0.00	0.00	0.00		XXX
J1240		E	INJECTION, DIMENHYDRINATE	0.00	0.00	0.00	0.00		XXX
J1320		E	INJECTION, AMITRIPTYLINE HCL	0.00	0.00	0.00	0.00		XXX
J1330		E	INJECTION, ERGONOVINE MALEATE	0.00	0.00	0.00	0.00		XXX
J1340		E	INJECTION, AQUEOUS SALINE PLACEBO	0.00	0.00	0.00	0.00		XXX
J1350		E	INJECTION, ERYTHROMYCIN-IM	0.00	0.00	0.00	0.00		XXX
J1360		E	INJECTION, ERTROMYCIN-IV	0.00	0.00	0.00	0.00		XXX
J1380		E	INJECTION, ESTRADIOL VALERATE	0.00	0.00	0.00	0.00		XXX
J1390		E	INJECTION, ESTRADIOL VALERATE	0.00	0.00	0.00	0.00		XXX
J1410		E	INJECTION, ESTROGEN CONJUGATED	0.00	0.00	0.00	0.00		XXX
J1435		E	INJECTION, ESTRONE	0.00	0.00	0.00	0.00		XXX
J1436		E	INJECTION, ETIDRONATE DISODIUM	0.00	0.00	0.00	0.00		XXX
J1460		E	INJECTION, GAMMA GLOBULIN	0.00	0.00	0.00	0.00		XXX
J1470		E	INJECTION, GAMMA GLOBULIN	0.00	0.00	0.00	0.00		XXX
J1480		E	INJECTION, GAMMA GLOBULIN	0.00	0.00	0.00	0.00		XXX
J1490		E	INJECTION, GAMMA GLOBULIN	0.00	0.00	0.00	0.00		XXX
J1500		E	INJECTION, GAMMA GLOBULIN	0.00	0.00	0.00	0.00		XXX
J1510		E	INJECTION, GAMMA GLOBULIN	0.00	0.00	0.00	0.00		XXX
J1520		E	INJECTION, GAMMA GLOBULIN	0.00	0.00	0.00	0.00		XXX
J1530		E	INJECTION, GAMMA GLOBULIN	0.00	0.00	0.00	0.00		XXX
J1540		E	INJECTION, GAMMA GLOBULIN	0.00	0.00	0.00	0.00		XXX
J1550		E	INJECTION, GAMMA GLOBULIN	0.00	0.00	0.00	0.00		XXX
J1560		E	INJECTION, GAMMA GLOBULIN	0.00	0.00	0.00	0.00		XXX
J1561		E	INJECTION, IMMUNE GLOBULIN	0.00	0.00	0.00	0.00		XXX
J1580		E	INJECTION, GARAMYCIN, GENTAMICIN	0.00	0.00	0.00	0.00		XXX
J1600		E	INJECTION, GOLD SODIUM THIOAMLEATE	0.00	0.00	0.00	0.00		XXX
J1630		E	INJECTION, HALOPERIDOL	0.00	0.00	0.00	0.00		XXX
J1631		E	INJECTION, HALOPERIDOL DECANOATE	0.00	0.00	0.00	0.00		XXX
J1640		E	INJECTION, HEPARIN SODIUM	0.00	0.00	0.00	0.00		XXX
J1660		E	INJECTION, HISTAMINE	0.00	0.00	0.00	0.00		XXX
J1670		E	INJECTION, TETANUS IMMUNE GLOBULIN	0.00	0.00	0.00	0.00		XXX
J1690		E	INJECTION, PREDNISOLONE TEBUTATE	0.00	0.00	0.00	0.00		XXX
J1700		E	INJECTION, HYDROCORTISONE ACETATE	0.00	0.00	0.00	0.00		XXX
J1710		E	INJECTION, HYDROCORTISONE SODIUM P	0.00	0.00	0.00	0.00		XXX
J1720		E	INJECTION, HYDROCORTISONE SODIUM S	0.00	0.00	0.00	0.00		XXX
J1730		E	INJECTION, DIAZOXIDE	0.00	0.00	0.00	0.00		XXX
J1739		E	INJECTION, HYDROXYPROGESTERONE CAP	0.00	0.00	0.00	0.00		XXX
J1741		E	INJECTION, HYDROXYPROGESTERONE CAP	0.00	0.00	0.00	0.00		XXX
J1760		E	INJECTION, IRON DEXTRAN	0.00	0.00	0.00	0.00		XXX
J1770		E	INJECTION, IRON DEXTRAN	0.00	0.00	0.00	0.00		XXX
J1780		E	INJECTION, IRON DEXTRAN	0.00	0.00	0.00	0.00		XXX
J1790		E	INJECTION, DROPERIDOL	0.00	0.00	0.00	0.00		XXX
J1800		E	INJECTION, PROPRANOLOL HCL	0.00	0.00	0.00	0.00		XXX
J1810		E	INJECTION, DROPERIDOL AND FENTANYL	0.00	0.00	0.00	0.00		XXX
J1820		E	INJECTION, INSULIN	0.00	0.00	0.00	0.00		XXX
J1840		E	INJECTION, KANAMYCIN SULFATE	0.00	0.00	0.00	0.00		XXX
J1850		E	INJECTION, KANAMYCIN SULFATE	0.00	0.00	0.00	0.00		XXX
J1890		E	INJECTION, CEPHALOTHIN SODIUM	0.00	0.00	0.00	0.00		XXX
J1910		E	INJECTION, KUTAPRESSIN	0.00	0.00	0.00	0.00		XXX
J1930		E	INJECTION, PROPIOMAZINE	0.00	0.00	0.00	0.00		XXX
J1940		E	INJECTION, FUROSEMIDE	0.00	0.00	0.00	0.00		XXX
J1960		E	INJECTION, LEVORPHANOL TARTRATE	0.00	0.00	0.00	0.00		XXX

ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
J1970		E	INJECTION, METHOTRIMEPRAZINE	0.00	0.00	0.00	0.00		XXX
J1980		E	INJECTION, HYOSCYAMINE SULFATE	0.00	0.00	0.00	0.00		XXX
J1990		E	INJECTION, CHLORDIAZEPOXIDE HCL	0.00	0.00	0.00	0.00		XXX
J2000		E	INJECTION, LIDOCAINE HCL	0.00	0.00	0.00	0.00		XXX
J2010		E	INJECTION, LINCOMYCIN HCL	0.00	0.00	0.00	0.00		XXX
J2050		E	INJECTION, LIVER	0.00	0.00	0.00	0.00		XXX
J2100		E	INJECTION, LUMINAL SODIUM	0.00	0.00	0.00	0.00		XXX
J2150		E	INJECTION, MANNITOL	0.00	0.00	0.00	0.00		XXX
J2160		E	INJECTION, CYCLIZINE LACTATE	0.00	0.00	0.00	0.00		XXX
J2175		E	INJECTION, MEPERIDINE	0.00	0.00	0.00	0.00		XXX
J2180		E	INJECTION, MEPERIDINE AND PROMETHA	0.00	0.00	0.00	0.00		XXX
J2190		E	INJECTION, MERSALYL WITH THEOPHYL.	0.00	0.00	0.00	0.00		XXX
J2210		E	INJECTION, METHYLERGONOVINE MALEAT	0.00	0.00	0.00	0.00		XXX
J2240		E	INJECTION, METOCURINE IODIDE	0.00	0.00	0.00	0.00		XXX
J2270		E	INJECTION, MORPHINE SULFATE	0.00	0.00	0.00	0.00		XXX
J2320		E	INJECTION, NANDROLONE DECANOATE	0.00	0.00	0.00	0.00		XXX
J2321		E	INJECTION, NANDROLONE DECANOATE	0.00	0.00	0.00	0.00		XXX
J2322		E	INJECTION, NANDROLONE DECANOATE	0.00	0.00	0.00	0.00		XXX
J2330		E	INJECTION, THIOTHIXENE	0.00	0.00	0.00	0.00		XXX
J2350		E	INJECTION, NIACINAMIDE, NIACIN	0.00	0.00	0.00	0.00		XXX
J2360		E	INJECTION, ORPHENADRINE	0.00	0.00	0.00	0.00		XXX
J2370		E	INJECTION, PHENYLEPHRINE HCL	0.00	0.00	0.00	0.00		XXX
J2400		E	INJECTION, CHLOROPROCAINE HCL	0.00	0.00	0.00	0.00		XXX
J2410		E	INJECTION, OXYMORPHONE HCL	0.00	0.00	0.00	0.00		XXX
J2440		E	INJECTION, PAPAVERINE HCL	0.00	0.00	0.00	0.00		XXX
J2460		E	INJECTION, OXYTETRACYCLINE HCL	0.00	0.00	0.00	0.00		XXX
J2480		E	INJECTION, HYDROCHLORIDES OF OPIUM	0.00	0.00	0.00	0.00		XXX
J2490		E	INJECTION, PARALDEHYDE	0.00	0.00	0.00	0.00		XXX
J2495		E	INJECTION, TRIDIHETHYL CHLORIDE	0.00	0.00	0.00	0.00		XXX
J2510		E	INJECTION, PENICILLIN G PROCAINE	0.00	0.00	0.00	0.00		XXX
J2515		E	INJECTION, PENTOBARBITAL SODIUM	0.00	0.00	0.00	0.00		XXX
J2520		E	INJECTION, THIOPENTAL SODIUM	0.00	0.00	0.00	0.00		XXX
J2540		E	INJECTION, PENICILLIN G POTASSIUM	0.00	0.00	0.00	0.00		XXX
J2545		E	PENTAMIDINE FOR INHALER	0.00	0.00	0.00	0.00		XXX
J2550		E	INJECTION, PROMETHAZINE HCL	0.00	0.00	0.00	0.00		XXX
J2560		E	INJECTION, PHENOBARBITAL SODIUM	0.00	0.00	0.00	0.00		XXX
J2590		E	INJECTION, OXYTOCIN	0.00	0.00	0.00	0.00		XXX
J2595		E	INJECTION, VASOPRESSIN TANNATE	0.00	0.00	0.00	0.00		XXX
J2600		E	INJECTION, POSTERIOR PITUITARY	0.00	0.00	0.00	0.00		XXX
J2640		E	INJECTION, PREDNISOLONE SODIUM PH.	0.00	0.00	0.00	0.00		XXX
J2650		E	INJECTION, PREDNISOLONE ACETATE	0.00	0.00	0.00	0.00		XXX
J2670		E	INJECTION, TOLAZOLINE HCL	0.00	0.00	0.00	0.00		XXX
J2672		E	INJECTION, PROPANTHELINE BROMIDE	0.00	0.00	0.00	0.00		XXX
J2675		E	INJECTION, PROGESTERONE	0.00	0.00	0.00	0.00		XXX
J2680		E	INJECTION, FLUPHENAZINE DECANOATE	0.00	0.00	0.00	0.00		XXX
J2690		E	INJECTION, PROCAINAMIDE HCL	0.00	0.00	0.00	0.00		XXX
J2700		E	INJECTION, OXACILLIN SODIUM	0.00	0.00	0.00	0.00		XXX
J2710		E	INJECTION, NEOSTIGMINE METHYLSULFT	0.00	0.00	0.00	0.00		XXX
J2720		E	INJECTION, PROTAMINE SULFATE	0.00	0.00	0.00	0.00		XXX
J2730		E	INJECTION, PRALIDOXIME CHLORIDE	0.00	0.00	0.00	0.00		XXX
J2760		E	INJECTION, PHENTOLAMINE MESYLATE	0.00	0.00	0.00	0.00		XXX
J2765		E	INJECTION, METOCLOPRAMIDE HCL	0.00	0.00	0.00	0.00		XXX
J2790		E	INJECTION, RHO D IMMUNE GLOBULIN	0.00	0.00	0.00	0.00		XXX
J2800		E	INJECTION, METHOCARBAMOL	0.00	0.00	0.00	0.00		XXX
J2810		E	INJECTION, THEOPHYLLINE	0.00	0.00	0.00	0.00		XXX
J2825		E	INJECTION, SARRACENIA PURPUREA	0.00	0.00	0.00	0.00		XXX
J2860		E	INJECTION, SECOBARBITAL SODIUM	0.00	0.00	0.00	0.00		XXX
J2910		E	INJECTION, AUROTHIOGLUCOSE	0.00	0.00	0.00	0.00		XXX
J2912		E	INJECTION, SODIUM CHLORIDE	0.00	0.00	0.00	0.00		XXX
J2914		E	INJECTION, SODIUM SALICYLATE	0.00	0.00	0.00	0.00		XXX
J2920		E	INJECTION, METHYLPREDNISOLONE	0.00	0.00	0.00	0.00		XXX
J2930		E	INJECTION, METHYLPREDNISOLONE	0.00	0.00	0.00	0.00		XXX
J2950		E	INJECTION, PROMAZINE HCL	0.00	0.00	0.00	0.00		XXX
J2970		E	INJECTION, METHICILLIN SODIUM	0.00	0.00	0.00	0.00		XXX
J2995		E	INJECTION, STREPTOKINASE	0.00	0.00	0.00	0.00		XXX
J3000		E	INJECTION, STREPTOMYCIN	0.00	0.00	0.00	0.00		XXX
J3010		E	INJECTION, FENTANYL CITRATE	0.00	0.00	0.00	0.00		XXX
J3050		E	INJECTION, DECAMETHONIUM BROMIDE	0.00	0.00	0.00	0.00		XXX
J3070		E	INJECTION, PENTAZOCINE HCL	0.00	0.00	0.00	0.00		XXX

ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
J3080		E	INJECTION, CHLORPROTHIXENE	0.00	0.00	0.00	0.00		XXX
J3105		E	INJECTION, TERBUTALINE SULFATE	0.00	0.00	0.00	0.00		XXX
J3120		E	INJECTION, TESTOSTERONE ENANTHATE	0.00	0.00	0.00	0.00		XXX
J3130		E	INJECTION, TESTOSTERONE ENANTHATE	0.00	0.00	0.00	0.00		XXX
J3140		E	INJECTION, TESTOSTERONE SUSPENSION	0.00	0.00	0.00	0.00		XXX
J3150		E	INJECTION, TESTOSTERONE PROPIONATE	0.00	0.00	0.00	0.00		XXX
J3180		E	INJECTION, TETANUS TOXOID	0.00	0.00	0.00	0.00		XXX
J3230		E	INJECTION, CHLORPROMAZINE HCL	0.00	0.00	0.00	0.00		XXX
J3240		E	INJECTION, THYROTROPIN	0.00	0.00	0.00	0.00		XXX
J3250		E	INJECTION, TRIMETHOBENZAMIDE HCL	0.00	0.00	0.00	0.00		XXX
J3260		E	INJECTION, TOBRAMYCIN SULFATE	0.00	0.00	0.00	0.00		XXX
J3270		E	INJECTION, IMIPRAMINE HCL	0.00	0.00	0.00	0.00		XXX
J3280		E	INJECTION, THIETHYLPERAZINE MALEAT	0.00	0.00	0.00	0.00		XXX
J3301		E	INJECTION TRIAMCINOLONE ACETONIDE	0.00	0.00	0.00	0.00		XXX
J3302		E	INJECTION TRIAMCINOLONE DIACETATE	0.00	0.00	0.00	0.00		XXX
J3303		E	INJECTION TRIAMCINOLONE HEXACETONI	0.00	0.00	0.00	0.00		XXX
J3310		E	INJECTION, PERPHENAZINE	0.00	0.00	0.00	0.00		XXX
J3320		E	INJECTION, SPECTINOMYCIN DIHYDROCH	0.00	0.00	0.00	0.00		XXX
J3340		E	INJECTION, CRYPTENAMINE ACETATE	0.00	0.00	0.00	0.00		XXX
J3350		E	INJECTION, UREA	0.00	0.00	0.00	0.00		XXX
J3360		E	INJECTION, DIAZEPAM	0.00	0.00	0.00	0.00		XXX
J3365		E	INJECTION, IV, UROKINASE	0.00	0.00	0.00	0.00		XXX
J3370		E	INJECTION, VANCOMYCIN HCL	0.00	0.00	0.00	0.00		XXX
J3380		E	INJECTION, ISOXSUPRINE HCL	0.00	0.00	0.00	0.00		XXX
J3390		E	INJECTION, METHOXAMINE	0.00	0.00	0.00	0.00		XXX
J3400		E	INJECTION, TRIFLUPROMAZINE HCL	0.00	0.00	0.00	0.00		XXX
J3410		E	INJECTION, HYDROXYZINE HCL	0.00	0.00	0.00	0.00		XXX
J3420		E	INJECTION, VITAMIN B- 12	0.00	0.00	0.00	0.00		XXX
J3430		E	INJECTION, VITAMIN K, PHYTONADIONE	0.00	0.00	0.00	0.00		XXX
J3450		E	INJECTION, MEPHENTERMINE SULFATE	0.00	0.00	0.00	0.00		XXX
J3470		E	INJECTION, HYALURONIDASE	0.00	0.00	0.00	0.00		XXX
J3490		E	UNCLASSIFIED DRUGS	0.00	0.00	0.00	0.00		XXX
J3500		E	VITAMIN THERAPY	0.00	0.00	0.00	0.00		XXX
J3520		N	ENDRATE ETHYLENEDIAMINE-TETRA-ACET	0.00	0.00	0.00	0.00		XXX
J3530		E	NASAL VACCINE INHALATION	0.00	0.00	0.00	0.00		XXX
J3540		E	AUTOGENOUS BLOOD EXTRACT, INTRAVEN	0.00	0.00	0.00	0.00		XXX
J3550		E	INTRA-ARTERIAL OXYGEN INJECTION	0.00	0.00	0.00	0.00		XXX
J3560		E	ADRENAL CORTEX EXTRACT	0.00	0.00	0.00	0.00		XXX
J3570		N	LAETRILE, AMYGDALIN, VITAMIN B17	0.00	0.00	0.00	0.00		XXX
J6015		N	TYPHUS	0.00	0.00	0.00	0.00		XXX
J7010		E	VIAL OF ALLERGY VACCINE, SINGLE	0.00	0.00	0.00	0.00		XXX
J7020		E	VIAL OF ALLERGY VACCINE, MULTIPLE	0.00	0.00	0.00	0.00		XXX
J7030		E	INFUSION, NORMAL SALINE SOLUTION	0.00	0.00	0.00	0.00		XXX
J7040		E	INFUSION, NORMAL SALINE SOLUTION	0.00	0.00	0.00	0.00		XXX
J7042		E	5% DEXTROSE/NORMAL SALINE	0.00	0.00	0.00	0.00		XXX
J7050		E	INFUSION, NORMAL SALINE SOLUTION	0.00	0.00	0.00	0.00		XXX
J7060		E	5% DEXTROSE/WATER	0.00	0.00	0.00	0.00		XXX
J7070		E	INFUSION, D5W	0.00	0.00	0.00	0.00		XXX
J7080		E	INFUSION, ALBUMISOL 5%	0.00	0.00	0.00	0.00		XXX
J7090		E	INFUSION, ALBUMISOL 25%	0.00	0.00	0.00	0.00		XXX
J7100		E	INFUSION, DEXTRAN 40	0.00	0.00	0.00	0.00		XXX
J7110		E	INFUSION, DEXTRAN 75	0.00	0.00	0.00	0.00		XXX
J7120		E	RINGERS LACTATE INFUSION	0.00	0.00	0.00	0.00		XXX
J7130		E	HYPERTONIC SALINE SOLUTION	0.00	0.00	0.00	0.00		XXX
J7140		E	PRESCRIPTION DRUG, ORAL	0.00	0.00	0.00	0.00		XXX
J7150		N	PRESCRIPTION DRUG, ORAL CHEMO.	0.00	0.00	0.00	0.00		XXX
J7190		E	FACTOR VIII	0.00	0.00	0.00	0.00		XXX
J7194		E	FACTOR IX, COMPLEX	0.00	0.00	0.00	0.00		XXX
J7196		E	OTHER HEMOPHILIA CLOTTING FACTORS	0.00	0.00	0.00	0.00		XXX
J7197		E	INJECTION, ANTITHROMBIN III	0.00	0.00	0.00	0.00		XXX
J7500		E	AZATHIOPRINE - ORAL, TAB	0.00	0.00	0.00	0.00		XXX
J7501		E	AZATHIOPRINE - PARENTERAL, VIAL	0.00	0.00	0.00	0.00		XXX
J7502		E	CYCLOSPORINE - ORAL, SOL.	0.00	0.00	0.00	0.00		XXX
J7503		E	CYCLOSPORINE - PARENTERAL	0.00	0.00	0.00	0.00		XXX
J7504		E	LYMPHOCYTE IMMUNE GLOBULIN	0.00	0.00	0.00	0.00		XXX
J7505		E	MONOCLONAL ANTIBODIES - PARENTERAL	0.00	0.00	0.00	0.00		XXX
J7506		E	PREDNISONE, ANY DOSAGE	0.00	0.00	0.00	0.00		XXX
J9000		E	DOXORUBICIN HCL	0.00	0.00	0.00	0.00		XXX
J9010		E	DOXORUBICIN HCL	0.00	0.00	0.00	0.00		XXX

ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
J9020		E	ASPARAGINASE	0.00	0.00	0.00	0.00		XXX
J9031		E	BCG LIVE (INTRAVESICAL)	0.00	0.00	0.00	0.00		XXX
J9040		E	BLEOMYCIN SULFATE	0.00	0.00	0.00	0.00		XXX
J9045		E	INJECTION, CARBOPLATIN	0.00	0.00	0.00	0.00		XXX
J9050		E	CARMUSTINE, BISCHLORETHYL NITRO.	0.00	0.00	0.00	0.00		XXX
J9060		E	CISPLATIN	0.00	0.00	0.00	0.00		XXX
J9062		E	CISPLATIN	0.00	0.00	0.00	0.00		XXX
J9070		E	CYCLOPHOSPHAMIDE	0.00	0.00	0.00	0.00		XXX
J9080		E	CYCLOPHOSPHAMIDE	0.00	0.00	0.00	0.00		XXX
J9090		E	CYCLOPHOSPHAMIDE	0.00	0.00	0.00	0.00		XXX
J9091		E	CYCLOPHOSPHAMIDE	0.00	0.00	0.00	0.00		XXX
J9092		E	CYCLOPHOSPHAMIDE	0.00	0.00	0.00	0.00		XXX
J9093		E	CYCLOPHOSPHAMIDE, LYOPHILIZED	0.00	0.00	0.00	0.00		XXX
J9094		E	CYCLOPHOSPHAMIDE, LYOPHILIZED	0.00	0.00	0.00	0.00		XXX
J9095		E	CYCLOPHOSPHAMIDE, LYOPHILIZED	0.00	0.00	0.00	0.00		XXX
J9096		E	CYCLOPHOSPHAMIDE, LYOPHILIZED	0.00	0.00	0.00	0.00		XXX
J9097		E	CYCLOPHOSPHAMIDE, LYOPHILIZED	0.00	0.00	0.00	0.00		XXX
J9100		E	CYTARABINE HCL	0.00	0.00	0.00	0.00		XXX
J9110		E	CYTARABINE HCL	0.00	0.00	0.00	0.00		XXX
J9120		E	DACTINOMYCIN, ACTINOMYCIN D	0.00	0.00	0.00	0.00		XXX
J9130		E	DACARBAZINE	0.00	0.00	0.00	0.00		XXX
J9140		E	DACARBAZINE	0.00	0.00	0.00	0.00		XXX
J9150		E	DAUNORUBICIN, HCL	0.00	0.00	0.00	0.00		XXX
J9165		E	INJECTION, DIETHYLSTILBESTROL	0.00	0.00	0.00	0.00		XXX
J9170		E	DROMOSTANOLONE, PROPIONATE	0.00	0.00	0.00	0.00		XXX
J9181		E	ETOPOSIDE	0.00	0.00	0.00	0.00		XXX
J9182		E	ETOPOSIDE	0.00	0.00	0.00	0.00		XXX
J9190		E	FLUOROURACIL	0.00	0.00	0.00	0.00		XXX
J9200		E	FLOXURIDINE	0.00	0.00	0.00	0.00		XXX
J9202		E	GOSERELIN ACETATE IMPLANT	0.00	0.00	0.00	0.00		XXX
J9208		E	INJECTION, IFOSFOMIDE	0.00	0.00	0.00	0.00		XXX
J9209		E	INJECTION, MESNA	0.00	0.00	0.00	0.00		XXX
J9212		E	INTERFERON	0.00	0.00	0.00	0.00		XXX
J9217		E	LEUPROLIDE ACETATE	0.00	0.00	0.00	0.00		XXX
J9218		N	LEUPROLIDE ACETATE	0.00	0.00	0.00	0.00		XXX
J9230		E	MECHLORETHAMINE HCL	0.00	0.00	0.00	0.00		XXX
J9240		E	MEDROXYPROGESTERONE ACETATE	0.00	0.00	0.00	0.00		XXX
J9250		E	METHOTREXATE SODIUM MIX	0.00	0.00	0.00	0.00		XXX
J9260		E	METHOTREXATE SODIUM MIX	0.00	0.00	0.00	0.00		XXX
J9270		E	PLICAMYCIN (MITHRAMYCIN)	0.00	0.00	0.00	0.00		XXX
J9280		E	MITOMYCIN	0.00	0.00	0.00	0.00		XXX
J9290		E	MITOMYCIN	0.00	0.00	0.00	0.00		XXX
J9291		E	MITOMYCIN	0.00	0.00	0.00	0.00		XXX
J9293		E	INJECTION, MITOXANTRONE HCL	0.00	0.00	0.00	0.00		XXX
J9295		E	POLYESTRADIOL PHOSPHATE	0.00	0.00	0.00	0.00		XXX
J9300		E	QUINACRINE HCL	0.00	0.00	0.00	0.00		XXX
J9320		E	STREPTOZOCIN	0.00	0.00	0.00	0.00		XXX
J9340		E	THIOTEPA	0.00	0.00	0.00	0.00		XXX
J9360		E	VINBLASTINE SULFATE	0.00	0.00	0.00	0.00		XXX
J9370		E	VINCRIStINE SULFATE	0.00	0.00	0.00	0.00		XXX
J9375		E	VINCRIStINE SULFATE	0.00	0.00	0.00	0.00		XXX
J9380		E	VINCRIStINE SULFATE	0.00	0.00	0.00	0.00		XXX
J9999		E	NOT OTHERWISE CLASSIFIED DRUGS	0.00	0.00	0.00	0.00		XXX
M0005		A	OFFICE VISITS - TWO OR MORE MODAL.	0.80	0.32	0.03	1.15	2	XXX
M0006		A	OFFICE VISITS - WITH ONE MODALITY	0.53	0.15	0.02	0.70	2	XXX
M0007		A	OFFICE VISIT COMBINATION OF MODAL.	1.06	0.36	0.04	1.46	2	XXX
M0008		A	OFFICE VISIT COMBINATION OF MODAL.	0.53	0.11	0.01	0.65	2	XXX
M0009		D	NOT OTHERWISE CLASSIFIED, OFFICE	0.00	0.00	0.00	0.00		XXX
M0019		D	NOT OTHERWISE CLASSIFIED, HOME	0.00	0.00	0.00	0.00		XXX
M0021		D	PER DIEM INPATIENT HOSPITAL CARE	0.00	0.00	0.00	0.00		XXX
M0022		V	I.C.U. CARE FOLLOW-UP	0.00	0.00	0.00	0.00		XXX
M0023		D	ROUTINE NEWBORN CARE, INHOSPITAL	0.00	0.00	0.00	0.00		XXX
M0029		D	NOT OTHERWISE CLASSIFIED, HOSP	0.00	0.00	0.00	0.00		XXX
M0039		D	NOT OTHERWISE CLASSIFIED, SNF, ECF	0.00	0.00	0.00	0.00		XXX
M0049		D	NOT OTHERWISE CLASSIFIED, NH	0.00	0.00	0.00	0.00		XXX
M0059		D	NOT OTHERWISE CLASSIFIED, EM. RM.	0.00	0.00	0.00	0.00		XXX
M0064		A	MONITORING DRUG PRESCRIPTION VISIT	0.38	0.29	0.03	0.70	2	XXX
M0070		D	INSULIN SHOCK THERAPY, HYPOGLYCEMI	0.00	0.00	0.00	0.00		XXX
M0071		D	ORTHOMOLECULAR THERAPY	0.00	0.00	0.00	0.00		XXX

ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
M0072		D	IMMUNOTHERAPY FOR MALIGNANT DISEAS	0.00	0.00	0.00	0.00		XXX
M0075		N	CELLULAR THERAPY	0.00	0.00	0.00	0.00		XXX
M0076		N	PROLOTHERAPY	0.00	0.00	0.00	0.00		XXX
M0080		D	HYPERTHERMIA THERAPY	0.00	0.00	0.00	0.00		XXX
M0100		N	INTRAGASTRIC HYPOTHERMIA	0.00	0.00	0.00	0.00		XXX
M0101		A	CUTTING OR REMOVAL OF CORNS	0.38	0.36	0.03	0.77	2	XXX
M0300		N	IV CHELATION THERAPY	0.00	0.00	0.00	0.00		XXX
M0301		N	FABRIC WRAPPING OF ABDOMINAL ANEUR	0.00	0.00	0.00	0.00		XXX
M0302		N	ASSESSMENT OF CARDIAC OUTPUT	0.00	0.00	0.00	0.00		XXX
M0520		D	ELECTRONIC PACEMAKER ANALYSIS	0.00	0.00	0.00	0.00		XXX
M0525		D	SINGLE LEAD EKG WITH ANALYSIS	0.00	0.00	0.00	0.00		XXX
M0526		D	COMPUTER TRACING AND INTERPRETATIO	0.00	0.00	0.00	0.00		XXX
M0530		D	CARDIAC EVENTS RECORDER, ECG	0.00	0.00	0.00	0.00		XXX
M0535		D	CARDIAC EVENTS RECORDER, ECG	0.00	0.00	0.00	0.00		XXX
M0540		D	SIGNAL-AVERAGING EKG	0.00	0.00	0.00	0.00		XXX
M0560		D	PNEUMOPLETHYSMOGRAPHY VENOUS OCCLU	0.00	0.00	0.00	0.00		XXX
M0575		D	ELECTROENCEPHALOGRAPH (EEG), INTERP	0.00	0.00	0.00	0.00		XXX
M0580		D	TRANSTELEPHONIC EEGS; COMPLETE	0.00	0.00	0.00	0.00		XXX
M0585		D	ACHILLES REFLEX RESPONSE	0.00	0.00	0.00	0.00		XXX
M0590		D	MONITORING ECG, EEG OR PRESSURE	0.00	0.00	0.00	0.00		XXX
M0601		D	PSYCHOLOGICAL TESTING, WITH REPORT	0.00	0.00	0.00	0.00		XXX
M0702		A	BRIEF, OSTEOPATHIC MANIP THERAPY	0.47	0.25	0.02	0.74	1	XXX
M0704		A	LIMITED, OSTEOPATHIC MANIP THERAPY	0.66	0.41	0.03	1.10	1	XXX
M0706		A	INTERMEDIATE OSTEOPATHIC MANIP THE	0.92	0.40	0.03	1.35	1	XXX
M0708		A	EXTENDED OSTEOPATHIC MANIP THERAPY	1.08	0.45	0.04	1.57	2	XXX
M0710		A	COMPREHENSIVE OSTEOPATHIC MANIP	1.25	0.40	0.03	1.68	1	XXX
M0722		A	BRIEF INPATIENT HOSPITAL OMT	0.47	0.62	0.05	1.14	2	XXX
M0724		A	LIMITED INPATIENT HOSPITAL OMT	0.69	0.85	0.07	1.61	1	XXX
M0726		A	INTERMEDIATE INPATIENT HOSPITAL OM	0.92	0.82	0.06	1.80	2	XXX
M0728		A	EXTENDED INPATIENT HOSPITAL OMT	1.07	0.36	0.03	1.46	1	XXX
M0730		A	COMPREHENSIVE INPATIENT HOSP OMT	1.25	0.55	0.04	1.84	2	XXX
M0799		D	PHYSICAL MEDICINE, NOC	0.00	0.00	0.00	0.00		XXX
M0900		A	EXCISION, REVISION OF A-V SHUNT	2.34	5.30	1.09	8.73	2	000
M0910		D	INSERTION CATHETERS FEMORAL VEIN	0.00	0.00	0.00	0.00		XXX
P2028		X	CEPHALIN FLOCCULATION, BLOOD	0.00	0.00	0.00	0.00		XXX
P2029		X	CONGO RED, BLOOD	0.00	0.00	0.00	0.00		XXX
P2031		N	HAIR ANALYSIS (EXCLUDING ARSENIC)	0.00	0.00	0.00	0.00		XXX
P2032		D	ICTERUS INDEX, BLOOD	0.00	0.00	0.00	0.00		XXX
P2033		X	THYMOL TURBIDITY, BLOOD	0.00	0.00	0.00	0.00		XXX
P2038		X	MUCOPROTEIN, BLOOD (SEROMUCOID)	0.00	0.00	0.00	0.00		XXX
P3000		X	SCREENING PAP SMEAR, CERVICAL	0.00	0.00	0.00	0.00		XXX
P3001		X	SCREENING PAP SMEAR, CERVICAL	0.00	0.00	0.00	0.00		XXX
P3001	26	A	SCREENING PAP SMEAR, CERVICAL	0.44	0.33	0.04	0.81	2	XXX
P7001		X	CULTURE, BACTERIAL, URINE	0.00	0.00	0.00	0.00		XXX
P7020		D	VACCINE, AUTOGENOUS	0.00	0.00	0.00	0.00		XXX
P9005		D	ADMINISTRATION FEE BY A PROVIDER	0.00	0.00	0.00	0.00		XXX
P9007		D	HANDLING CHARGE FOR PURCHASED LAB	0.00	0.00	0.00	0.00		XXX
P9010		E	BLOOD (WHOLE), FOR TRANSFUSION	0.00	0.00	0.00	0.00		XXX
P9011		E	BLOOD (SPLIT UNIT), SPECIFY AMOUNT	0.00	0.00	0.00	0.00		XXX
P9012		E	CRYOPRECIPITATE, EACH UNIT	0.00	0.00	0.00	0.00		XXX
P9013		E	FIBRINOGEN UNIT	0.00	0.00	0.00	0.00		XXX
P9014		E	GLOBULIN, GAMMA	0.00	0.00	0.00	0.00		XXX
P9015		E	GLOBULIN, RH IMMUNE.	0.00	0.00	0.00	0.00		XXX
P9016		E	LEUKOCYTE POOR BLOOD, EACH UNIT	0.00	0.00	0.00	0.00		XXX
P9017		E	PLASMA, SINGLE DONOR, FRESH FROZEN	0.00	0.00	0.00	0.00		XXX
P9018		E	PLASMA PROTEIN FRACTION, EACH UNIT	0.00	0.00	0.00	0.00		XXX
P9019		E	PLATELET CONCENTRATE, EACH UNIT	0.00	0.00	0.00	0.00		XXX
P9020		E	PLATELET RICH PLASMA, EACH UNIT	0.00	0.00	0.00	0.00		XXX
P9021		E	RED BLOOD CELLS, EACH UNIT	0.00	0.00	0.00	0.00		XXX
P9022		E	WASHED RED BLOOD CELLS, EACH UNIT	0.00	0.00	0.00	0.00		XXX
P9023		D	FACTOR VIII CONCENTRATE, LYOPHIL.	0.00	0.00	0.00	0.00		XXX
P9024		D	FACTOR VIII DILUTION, EACH BOTTLE.	0.00	0.00	0.00	0.00		XXX
P9603		X	TRAVEL ALLOWANCE ONE WAY - LAB	0.00	0.00	0.00	0.00		XXX
P9604		X	TRAVEL ALLOWANCE ONE WAY - LAB	0.00	0.00	0.00	0.00		XXX
P9605		X	ROUTINE VENIPUNCTURE	0.00	0.00	0.00	0.00		XXX
P9610		X	CATHETERIZATION SPECIMEN COLLECT	0.00	0.00	0.00	0.00		XXX
P9615		X	CATHETERIZATION SPECIMEN COLLECT	0.00	0.00	0.00	0.00		XXX
Q0034		X	ADMINISTRATION - INFLUENZA VACCINE	0.00	0.00	0.00	0.00		XXX
Q0035		A	CARDIOKYMNOGRAPHY	0.18	0.42	0.03	0.63	2	XXX

ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
Q0035	TC	A	CARDIOKYMOGRAPHY	0.00	0.30	0.02	0.32		XXX
Q0035	26	A	CARDIOKYMOGRAPHY	0.18	0.12	0.01	0.31	2	XXX
Q0036		X	OXYGEN CONCENTRATOR, HIGH HUMIDITY	0.00	0.00	0.00	0.00		XXX
Q0038		X	OXYGEN CONTENTS, GASEOUS, PER UNIT	0.00	0.00	0.00	0.00		XXX
Q0039		X	OXYGEN CONTENTS, LIQUID, PER UNIT	0.00	0.00	0.00	0.00		XXX
Q0040		X	PORTABLE OXYGEN CONTENTS, GASEOUS	0.00	0.00	0.00	0.00		XXX
Q0041		X	PORTABLE OXYGEN CONTENTS, LIQUID	0.00	0.00	0.00	0.00		XXX
Q0042		X	STATIONARY COMPRESSED GAS SYSTEM	0.00	0.00	0.00	0.00		XXX
Q0043		X	STATIONARY LIQUID OXYGEN SYSTEM	0.00	0.00	0.00	0.00		XXX
Q0044		D	BRIEF OFFICE VISIT - MONITORING	0.00	0.00	0.00	0.00		XXX
Q0046		X	PORTABLE LIQUID OXYGEN SYSTEM	0.00	0.00	0.00	0.00		XXX
Q0060		D	SCREENING PAPANICOLAOU SMEAR	0.00	0.00	0.00	0.00		XXX
Q0061		D	SCREENING, PAPANICOLAOU SMEAR	0.00	0.00	0.00	0.00		XXX
Q0066		D	ASSESSMENT OF CARDIAC OUTPUT	0.00	0.00	0.00	0.00		XXX
Q0068		A	EXTRACORPOREAL PLASMAPHERESIS	1.76	1.34	0.16	3.26	2	000
Q0069		D	MAGNETIC IMAGE, BRAIN (MRI)	0.00	0.00	0.00	0.00		XXX
Q0070		D	MAGNETIC IMAGE, SPINE (MRI)	0.00	0.00	0.00	0.00		XXX
Q0071		D	MAGNETIC IMAGE, SPINE (MRI)	0.00	0.00	0.00	0.00		XXX
Q0072		D	MAGNETIC IMAGE, SPINE (MRI)	0.00	0.00	0.00	0.00		XXX
Q0087		D	INJECTION, DEFROXAMINE MESYLATE	0.00	0.00	0.00	0.00		XXX
Q0088		D	INJECTION, CALCITRIOL	0.00	0.00	0.00	0.00		XXX
Q0089		D	INJECTION, IV, UROKINASE	0.00	0.00	0.00	0.00		XXX
Q0090		D	INJECTION, CEFOTAXIME SODIUM	0.00	0.00	0.00	0.00		XXX
Q0091		A	SCREENING PAP SMEAR, OBTAINING	0.38	0.29	0.03	0.70	2	XXX
Q0092		A	SET-UP PORTABLE X-RAY EQUIPMENT	0.00	0.22	0.01	0.23		XXX
Q9920		E	INJECTION OF EPO, PER 1000 UNITS	0.00	0.00	0.00	0.00		XXX
Q9921		E	INJECTION OF EPO, PER 1000 UNITS	0.00	0.00	0.00	0.00		XXX
Q9922		E	INJECTION OF EPO, PER 1000 UNITS	0.00	0.00	0.00	0.00		XXX
Q9923		E	INJECTION OF EPO, PER 1000 UNITS	0.00	0.00	0.00	0.00		XXX
Q9924		E	INJECTION OF EPO, PER 1000 UNITS	0.00	0.00	0.00	0.00		XXX
Q9925		E	INJECTION OF EPO, PER 1000 UNITS	0.00	0.00	0.00	0.00		XXX
Q9926		E	INJECTION OF EPO, PER 1000 UNITS	0.00	0.00	0.00	0.00		XXX
Q9927		E	INJECTION OF EPO, PER 1000 UNITS	0.00	0.00	0.00	0.00		XXX
Q9928		E	INJECTION OF EPO, PER 1000 UNITS	0.00	0.00	0.00	0.00		XXX
Q9929		E	INJECTION OF EPO, PER 1000 UNITS	0.00	0.00	0.00	0.00		XXX
Q9930		E	INJECTION OF EPO, PER 1000 UNITS	0.00	0.00	0.00	0.00		XXX
Q9931		E	INJECTION OF EPO, PER 1000 UNITS	0.00	0.00	0.00	0.00		XXX
Q9932		E	INJECTION OF EPO, PER 1000 UNITS	0.00	0.00	0.00	0.00		XXX
Q9933		E	INJECTION OF EPO, PER 1000 UNITS	0.00	0.00	0.00	0.00		XXX
Q9934		E	INJECTION OF EPO, PER 1000 UNITS	0.00	0.00	0.00	0.00		XXX
Q9935		E	INJECTION OF EPO, PER 1000 UNITS	0.00	0.00	0.00	0.00		XXX
Q9936		E	INJECTION OF EPO, PER 1000 UNITS	0.00	0.00	0.00	0.00		XXX
Q9937		E	INJECTION OF EPO, PER 1000 UNITS	0.00	0.00	0.00	0.00		XXX
Q9938		E	INJECTION OF EPO, PER 1000 UNITS	0.00	0.00	0.00	0.00		XXX
Q9939		E	INJECTION OF EPO, PER 1000 UNITS	0.00	0.00	0.00	0.00		XXX
Q9940		E	INJECTION OF EPO, PER 1000 UNITS	0.00	0.00	0.00	0.00		XXX
R0070		C	TRANSPORTATION OF PORTABLE X-RAY	0.00	0.00	0.00	0.00		XXX
R0075		C	TRANSPORTATION OF PORTABLE X-RAY	0.00	0.00	0.00	0.00		XXX
R0076		C	TRANSPORTATION OF PORTABLE EKG	0.00	0.00	0.00	0.00		XXX
V2020		X	FRAMES, PURCHASES	0.00	0.00	0.00	0.00		XXX
V2100		X	SPHERE, SINGLE VISION	0.00	0.00	0.00	0.00		XXX
V2101		X	SPHERE, SINGLE VISION	0.00	0.00	0.00	0.00		XXX
V2102		X	SPHERE, SINGLE VISION	0.00	0.00	0.00	0.00		XXX
V2103		X	SPHEROCYLINDER, SINGLE VISION	0.00	0.00	0.00	0.00		XXX
V2104		X	SPHEROCYLINDER, SINGLE VISION	0.00	0.00	0.00	0.00		XXX
V2105		X	SPHEROCYLINDER, SINGLE VISION	0.00	0.00	0.00	0.00		XXX
V2106		X	SPHEROCYLINDER, SINGLE VISION	0.00	0.00	0.00	0.00		XXX
V2107		X	SPHEROCYLINDER, SINGLE VISION	0.00	0.00	0.00	0.00		XXX
V2108		X	SPHEROCYLINDER, SINGLE VISION	0.00	0.00	0.00	0.00		XXX
V2109		X	SPHEROCYLINDER, SINGLE VISION	0.00	0.00	0.00	0.00		XXX
V2110		X	SPEROCYLINDER, SINGLE VISION	0.00	0.00	0.00	0.00		XXX
V2111		X	SPHEROCYLINDER, SINGLE VISION	0.00	0.00	0.00	0.00		XXX
V2112		X	SPHEROCYLINDER, SINGLE VISION	0.00	0.00	0.00	0.00		XXX
V2113		X	SPHEROCYLINDER, SINGLE VISION	0.00	0.00	0.00	0.00		XXX
V2114		X	SPHEROCYLINDER, SINGLE VISION	0.00	0.00	0.00	0.00		XXX
V2115		X	LENTICULAR, (MYODISC), PER LENS	0.00	0.00	0.00	0.00		XXX
V2116		X	LENTICULAR LENS, NONASPHERIC	0.00	0.00	0.00	0.00		XXX
V2117		X	LENTICULAR, ASPHERIC, PER LENS	0.00	0.00	0.00	0.00		XXX
V2118		X	ANISEIKONIC LENS, SINGLE VISION	0.00	0.00	0.00	0.00		XXX

ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
V2199		X	NOT OTHERWISE CLASSIFIED	0.00	0.00	0.00	0.00		XXX
V2200		X	SPHERE, BIFOCAL	0.00	0.00	0.00	0.00		XXX
V2201		X	SPHERE, BIFOCAL	0.00	0.00	0.00	0.00		XXX
V2202		X	SPHERE, BIFOCAL	0.00	0.00	0.00	0.00		XXX
V2203		X	SPHEROCYLINDER, BIFOCAL	0.00	0.00	0.00	0.00		XXX
V2204		X	SPHEROCYLINDER, BIFOCAL	0.00	0.00	0.00	0.00		XXX
V2205		X	SPHEROCYLINDER, BIFOCAL	0.00	0.00	0.00	0.00		XXX
V2206		X	SPHEROCYLINDER, BIFOCAL	0.00	0.00	0.00	0.00		XXX
V2207		X	SPHEROCYLINDER, BIFOCAL	0.00	0.00	0.00	0.00		XXX
V2208		X	SPHEROCYLINDER, BIFOCAL	0.00	0.00	0.00	0.00		XXX
V2209		X	SPHEROCYLINDER, BIFOCAL	0.00	0.00	0.00	0.00		XXX
V2210		X	SPHEROCYLINDER, BIFOCAL	0.00	0.00	0.00	0.00		XXX
V2211		X	SPHEROCYLINDER, BIFOCAL	0.00	0.00	0.00	0.00		XXX
V2212		X	SPHEROCYLINDER, BIFOCAL	0.00	0.00	0.00	0.00		XXX
V2213		X	SPHEROCYLINDER, BIFOCAL	0.00	0.00	0.00	0.00		XXX
V2214		X	SPHEROCYLINDER, BIFOCAL	0.00	0.00	0.00	0.00		XXX
V2215		X	LENTICULAR (MYODISC), PER LENS	0.00	0.00	0.00	0.00		XXX
V2216		X	LENTICULAR, NONASPHERIC, PER LENS	0.00	0.00	0.00	0.00		XXX
V2217		X	LENTICULAR, ASPHERIC LENS, BIFOCAL	0.00	0.00	0.00	0.00		XXX
V2218		X	ANISEIKONIC, PER LENS, BIFOCAL	0.00	0.00	0.00	0.00		XXX
V2219		X	BIFOCAL SEG WIDTH OVER 28MM	0.00	0.00	0.00	0.00		XXX
V2220		X	BIFOCAL ADD OVER 3.25D	0.00	0.00	0.00	0.00		XXX
V2299		X	SPECIALTY BIFOCAL (BY REPORT)	0.00	0.00	0.00	0.00		XXX
V2300		X	SPHERE, TRIFOCAL	0.00	0.00	0.00	0.00		XXX
V2301		X	SPHERE, TRIFOCAL	0.00	0.00	0.00	0.00		XXX
V2302		X	SPHERE, TRIFOCAL	0.00	0.00	0.00	0.00		XXX
V2303		X	SPHEROCYLINDER, TRIFOCAL	0.00	0.00	0.00	0.00		XXX
V2304		X	SPHEROCYLINDER, TRIFOCAL	0.00	0.00	0.00	0.00		XXX
V2305		X	SPHEROCYLINDER, TRIFOCAL	0.00	0.00	0.00	0.00		XXX
V2306		X	SPHEROCYLINDER, TRIFOCAL	0.00	0.00	0.00	0.00		XXX
V2307		X	SPHEROCYLINDER, TRIFOCAL	0.00	0.00	0.00	0.00		XXX
V2308		X	SPHEROCYLINDER, TRIFOCAL	0.00	0.00	0.00	0.00		XXX
V2309		X	SPHEROCYLINDER, TRIFOCAL	0.00	0.00	0.00	0.00		XXX
V2310		X	SPHEROCYLINDER, TRIFOCAL	0.00	0.00	0.00	0.00		XXX
V2311		X	SPHEROCYLINDER, TRIFOCAL	0.00	0.00	0.00	0.00		XXX
V2312		X	SPHEROCYLINDER, TRIFOCAL	0.00	0.00	0.00	0.00		XXX
V2313		X	SPHEROCYLINDER, TRIFOCAL	0.00	0.00	0.00	0.00		XXX
V2314		X	SPHEROCYLINDER, TRIFOCAL	0.00	0.00	0.00	0.00		XXX
V2315		X	LENTICULAR, (MYODISC), PER LENS	0.00	0.00	0.00	0.00		XXX
V2316		X	LENTICULAR NONASPHERIC, PER LENS	0.00	0.00	0.00	0.00		XXX
V2317		X	LENTICULAR, ASPHERIC LENS	0.00	0.00	0.00	0.00		XXX
V2318		X	ANISEIKONIC LENS, TRIFOCAL	0.00	0.00	0.00	0.00		XXX
V2319		X	TRIFOCAL SEG WIDTH OVER 28 MM	0.00	0.00	0.00	0.00		XXX
V2320		X	TRIFOCAL ADD OVER 3.25D	0.00	0.00	0.00	0.00		XXX
V2399		X	SPECIALTY TRIFOCAL (BY REPORT)	0.00	0.00	0.00	0.00		XXX
V2410		X	VARIABLE ASPHERICITY LENS	0.00	0.00	0.00	0.00		XXX
V2430		X	VARIABLE ASPHERICITY LENS, BIFOCAL	0.00	0.00	0.00	0.00		XXX
V2499		X	VARIABLE SPHERICITY LENS	0.00	0.00	0.00	0.00		XXX
V2500		X	CONTACT LENS, PMMA, SPHERICAL	0.00	0.00	0.00	0.00		XXX
V2501		X	CONTACT LENS, PMMA, TORIC OR PRISM	0.00	0.00	0.00	0.00		XXX
V2502		X	CONTACT LENS PMMA, BIFOCAL	0.00	0.00	0.00	0.00		XXX
V2503		X	CONTACT LENS PMMA, COLOR VISION	0.00	0.00	0.00	0.00		XXX
V2510		X	CONTACT LENS, GAS PERMEABLE	0.00	0.00	0.00	0.00		XXX
V2511		X	CONTACT LENS, GAS PERMEABLE, TORIC	0.00	0.00	0.00	0.00		XXX
V2512		X	CONTACT LENS, GAS PERMEABLE	0.00	0.00	0.00	0.00		XXX
V2513		X	CONTACT LENS, GAS PERMEABLE	0.00	0.00	0.00	0.00		XXX
V2520		X	CONTACT LENS HYDROPHILIC	0.00	0.00	0.00	0.00		XXX
V2521		X	CONTACT LENS HYDROPHILIC, TORIC	0.00	0.00	0.00	0.00		XXX
V2522		X	CONTACT LENS HYDROPHILIC, BIFOCAL	0.00	0.00	0.00	0.00		XXX
V2523		X	CONTACT LENS HYDROPHILIC, EXTENDED	0.00	0.00	0.00	0.00		XXX
V2530		X	CONTACT LENS, SCLERAL, PER LENS	0.00	0.00	0.00	0.00		XXX
V2599		X	CONTACT LENS, OTHER TYPE	0.00	0.00	0.00	0.00		XXX
V2600		X	HAND HELD LOW VISION AIDS	0.00	0.00	0.00	0.00		XXX
V2610		X	SINGLE LENS SPECTACLE MOUNTED	0.00	0.00	0.00	0.00		XXX
V2615		X	TELESCOPIC AND OTHER COMPOUND LENS	0.00	0.00	0.00	0.00		XXX
V2620		X	PROSTHETIC, EYE, GLASS, STOCK	0.00	0.00	0.00	0.00		XXX
V2621		X	PROSTHETIC, EYE PLASTIC, STOCK	0.00	0.00	0.00	0.00		XXX
V2622		X	PROSTHETIC, EYE, GLASS, CUSTOM	0.00	0.00	0.00	0.00		XXX
V2623		X	PROSTHETIC EYE, PLASTIC, CUSTOM	0.00	0.00	0.00	0.00		XXX

ADDENDUM B
RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION

HCPCS	MOD	STATUS	DESCRIPTION	WORK RVUs	PRACTICE EXPENSE RVUs	MAL- PRACTICE RVUs	TOTAL RVUs	SOURCE OF WORK RVUs	GLOBAL FEE PERIOD
V2629		X	PROSTHETIC EYE, OTHER TYPE	0.00	0.00	0.00	0.00		XXX
V2630		X	ANTERIOR CHAMBER INTRAOCULAR LENS	0.00	0.00	0.00	0.00		XXX
V2631		X	IRIS SUPPORTED INTRAOCULAR LENS	0.00	0.00	0.00	0.00		XXX
V2632		X	POSTERIOR CHAMBER INTRAOCULAR LENS	0.00	0.00	0.00	0.00		XXX
V2700		X	BALANCE LENS, PER LENS	0.00	0.00	0.00	0.00		XXX
V2710		X	SLAB OFF PRISM, GLASS OR PLASTIC	0.00	0.00	0.00	0.00		XXX
V2715		X	PRISM, PER LENS	0.00	0.00	0.00	0.00		XXX
V2718		X	PRESS-ON LENS, FRESNELL PRISM	0.00	0.00	0.00	0.00		XXX
V2730		X	SPECIAL BASE CURVE	0.00	0.00	0.00	0.00		XXX
V2740		X	TINT, PLASTIC, ROSE	0.00	0.00	0.00	0.00		XXX
V2741		X	TINT, PLASTIC, OTHER THAN ROSE 1-2	0.00	0.00	0.00	0.00		XXX
V2742		X	TINT, GLASS ROSE 1 OR 2, PER LENS	0.00	0.00	0.00	0.00		XXX
V2743		X	TINT, GLASS OTHER THAN ROSE 1 OR 2	0.00	0.00	0.00	0.00		XXX
V2744		X	TINT, PHOTOCHROMATIC, PER LENS	0.00	0.00	0.00	0.00		XXX
V2750		X	ANTI-REFLECTIVE COATING, PER LENS	0.00	0.00	0.00	0.00		XXX
V2755		X	U-V LENS, PER LENS	0.00	0.00	0.00	0.00		XXX
V2760		X	SCRATCH RESISTANT COATING	0.00	0.00	0.00	0.00		XXX
V2770		X	OCCLUDER LENS, PER LENS	0.00	0.00	0.00	0.00		XXX
V2780		X	OVERSIZE LENS, PER LENS	0.00	0.00	0.00	0.00		XXX
V2785		X	PROCESSING, TRANSP CORNEAL TISSUE	0.00	0.00	0.00	0.00		XXX
V2799		X	VISION SERVICE, MISCELLANEOUS	0.00	0.00	0.00	0.00		XXX
V5000		D	BASIC AUDIOLOGIC ASSESSMENT	0.00	0.00	0.00	0.00		XXX
V5001		D	COMPREHENSIVE AUDIOLOGIC ASSESS	0.00	0.00	0.00	0.00		XXX
V5002		D	ASSESSMENT OF VESTIBULAR / AUDIO	0.00	0.00	0.00	0.00		XXX
V5003		D	ASSESSMENT OF VESTIBULAR / AUDIO	0.00	0.00	0.00	0.00		XXX
V5008		N	HEARING SCREENING	0.00	0.00	0.00	0.00		XXX
V5010		N	ASSESSMENT FOR HEARING AID	0.00	0.00	0.00	0.00		XXX
V5011		N	FITTING/CHECKING OF HEARING AID	0.00	0.00	0.00	0.00		XXX
V5012		D	COMPLETE COCHLEAR IMPLANT REHAB	0.00	0.00	0.00	0.00		XXX
V5014		N	REPAIR/MODIF OF A HEARING AID	0.00	0.00	0.00	0.00		XXX
V5016		D	UNLISTED AUDIOLOGIC PROCEDURE	0.00	0.00	0.00	0.00		XXX
V5020		N	CONFORMITY EVALUATION	0.00	0.00	0.00	0.00		XXX
V5030		N	HEARING AID, MONAURAL, BODY WORN	0.00	0.00	0.00	0.00		XXX
V5040		N	HEARING AID, MONAURAL, BODY WORN	0.00	0.00	0.00	0.00		XXX
V5050		N	HEARING AID, MONAURAL, IN THE EAR	0.00	0.00	0.00	0.00		XXX
V5060		N	HEARING AID, MONAURAL, BEHIND EAR	0.00	0.00	0.00	0.00		XXX
V5070		N	GLASSES, AIR CONDUCTION	0.00	0.00	0.00	0.00		XXX
V5080		N	GLASSES, BONE CONDUCTION	0.00	0.00	0.00	0.00		XXX
V5090		N	DISPENSING FEE, UNSPEC HEARING AID	0.00	0.00	0.00	0.00		XXX
V5100		N	HEARING AID, BILATERAL, BODY WORN	0.00	0.00	0.00	0.00		XXX
V5110		N	DISPENSING FEE, BILATERAL	0.00	0.00	0.00	0.00		XXX
V5120		N	BINAURAL, BODY	0.00	0.00	0.00	0.00		XXX
V5130		N	BINAURAL, IN THE EAR	0.00	0.00	0.00	0.00		XXX
V5140		N	BINAURAL, BEHIND THE EAR	0.00	0.00	0.00	0.00		XXX
V5150		N	BINAURAL, GLASSES	0.00	0.00	0.00	0.00		XXX
V5160		N	DISPENSING FEE, BINAURAL	0.00	0.00	0.00	0.00		XXX
V5170		N	HEARING AID, CROS, IN THE EAR	0.00	0.00	0.00	0.00		XXX
V5180		N	HEARING AID, CROS, BEHIND THE EAR	0.00	0.00	0.00	0.00		XXX
V5190		N	HEARING AID, CROS, GLASSES	0.00	0.00	0.00	0.00		XXX
V5200		N	DISPENSING FEE, CROS	0.00	0.00	0.00	0.00		XXX
V5210		N	HEARING AID, BICROS, IN THE EAR	0.00	0.00	0.00	0.00		XXX
V5220		N	HEARING AID, BICROS, BEHIND EAR	0.00	0.00	0.00	0.00		XXX
V5230		N	HEARING AID, BICROS, GLASSES	0.00	0.00	0.00	0.00		XXX
V5240		N	DISPENSING FEE, BICROS	0.00	0.00	0.00	0.00		XXX
V5299		N	HEARING SERVICE, MISCELLANEOUS	0.00	0.00	0.00	0.00		XXX
V5301		D	BASIC ASSESSMENT OF SPEECH, VOICE	0.00	0.00	0.00	0.00		XXX
V5310		D	COMPREHENSIVE ASSESSMENT OF SPEECH	0.00	0.00	0.00	0.00		XXX
V5321		D	ASSESSMENT FOR ORAL OR LARYNGEAL	0.00	0.00	0.00	0.00		XXX
V5322		D	ASSESSMENT FOR AUGMENTATIVE COMMUN	0.00	0.00	0.00	0.00		XXX
V5330		D	TREATMENT FOR SPEECH, LANGUAGE	0.00	0.00	0.00	0.00		XXX
V5335		D	REPAIR/MODIFICATION OF ORAL	0.00	0.00	0.00	0.00		XXX
V5336		N	REPAIR/MODIFICATION AUGMEN DEVICE	0.00	0.00	0.00	0.00		XXX
V5360		D	UNLISTED SPEECH-LANGUAGE SERVICE	0.00	0.00	0.00	0.00		XXX
V5362		N	SPEECH SCREENING	0.00	0.00	0.00	0.00		XXX
V5363		N	LANGUAGE SCREENING	0.00	0.00	0.00	0.00		XXX
V5364		N	DYSPHAGIA SCREENING	0.00	0.00	0.00	0.00		XXX

ADDENDUM C

TABLE 1

GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER LOCALITY

CARRIER NUMBER	LOCALITY NUMBER	LOCALITY NAME	WORK	PRACTICE EXPENSE	MAL- PRACTICE
510	5	BIRMINGHAM, AL	0.981	0.913	0.824
510	4	MOBILE, AL	0.964	0.911	0.824
510	2	NORTH CENTRAL AL	0.970	0.867	0.824
510	1	NORTHWEST AL	0.985	0.869	0.824
510	6	REST OF AL	0.975	0.851	0.824
510	3	SOUTHEAST AL	0.972	0.869	0.824
1020	1	ALASKA	1.106	1.255	1.042
1030	5	FLAGSTAFF (CITY), AZ	0.983	0.911	1.255
1030	1	PHOENIX, AZ	1.003	1.016	1.255
1030	7	PRESCOTT (CITY), AZ	0.983	0.911	1.255
1030	99	REST OF ARIZONA	0.987	0.943	1.255
1030	2	TUCSON (CITY), AZ	0.987	0.989	1.255
1030	8	YUMA (CITY), AZ	0.983	0.911	1.255
520	13	ARKANSAS	0.960	0.856	0.302
2050	26	ANAHEIM-SANTA ANA, CA	1.046	1.220	1.370
542	14	BAKERSFIELD, CA	1.028	1.050	1.370
542	11	FRESNO/MADERA, CA	1.006	1.009	1.370
542	13	KINGS/TULARE, CA	0.999	1.001	1.370
2050	18	LOS ANGELES, CA (1ST OF 8)	1.060	1.196	1.370
2050	19	LOS ANGELES, CA (2ND OF 8)	1.060	1.196	1.370
2050	20	LOS ANGELES, CA (3RD OF 8)	1.060	1.196	1.370
2050	21	LOS ANGELES, CA (4TH OF 8)	1.060	1.196	1.370
2050	22	LOS ANGELES, CA (5TH OF 8)	1.060	1.196	1.370
2050	23	LOS ANGELES, CA (6TH OF 8)	1.060	1.196	1.370
2050	24	LOS ANGELES, CA (7TH OF 8)	1.060	1.196	1.370
2050	25	LOS ANGELES, CA (8TH OF 8)	1.060	1.196	1.370
542	3	MARIN/NAPA/SOLANO, CA	1.012	1.198	1.370
542	10	MERCED/SURR. CNTYS, CA	1.018	1.009	1.370
542	12	MONTEREY/SANTA CRUZ, CA	1.023	1.108	1.370
542	1	N. COASTAL CNTYS, CA	1.003	1.072	1.370
542	2	NE RURAL CA	1.001	0.990	1.370
542	7	OAKLAND-BERKELEY, CA	1.028	1.258	1.370
542	27	RIVERSIDE, CA	1.026	1.080	1.370
542	4	SACRAMENTO/SURR. CNTYS, CA	1.026	1.088	1.370
542	15	SAN BERNARDINO/E.CNTRL CA	1.025	1.077	1.370
2050	28	SAN DIEGO/IMPERIAL, CA	1.026	1.090	1.370
542	5	SAN FRANCISCO, CA	1.038	1.303	1.370
542	6	SAN MATEO, CA	1.038	1.303	1.370
2050	16	SANTA BARBARA, CA	1.012	1.073	1.370
542	9	SANTA CLARA, CA	1.048	1.286	1.370
542	8	STOCKTON/SURR. CNTYS, CA	1.019	1.027	1.370
2050	17	VENTURA, CA	1.034	1.132	1.370
550	1	COLORADO	0.999	0.988	0.683
10230	4	EASTERN CONN.	0.999	1.053	1.036

ADDENDUM C

TABLE 1

GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER LOCALITY

(continued)

CARRIER NUMBER	LOCALITY NUMBER	LOCALITY NAME	WORK	PRACTICE EXPENSE	MAL- PRACTICE
10230	1	NW AND N.CENTRAL CONN.	1.002	1.071	1.025
10230	3	SOUTH CENTRAL CONN.	1.018	1.103	1.188
10230	2	SW CONNECTICUT	1.053	1.139	1.231
570	1	DELAWARE	1.026	1.018	0.664
580	1	D.C. + MD/VA SUBURBS	1.059	1.168	0.947
590	3	FORT LAUDERDALE, FL	0.993	0.981	1.376
590	4	MIAMI, FL	1.034	1.025	1.641
590	2	N/NC FLORIDA CITIES	0.975	0.932	1.108
590	1	REST OF FLORIDA	0.966	0.871	1.108
1040	1	ATLANTA, GA	0.975	1.022	0.752
1040	4	REST OF GEORGIA	0.956	0.841	0.752
1040	2	SMALL GA CITIES 02	0.962	0.895	0.752
1040	3	SMALL GA CITIES 03	0.961	0.869	0.752
1120	1	HAWAII	1.003	1.094	1.025
5130	12	NORTH IDAHO	0.965	0.917	0.889
5130	11	SOUTH IDAHO	0.967	0.936	0.889
621	10	CHAMPAIGN-URBANA, IL	0.965	0.920	1.137
621	16	CHICAGO, IL	1.044	1.114	1.773
621	3	DE KALB, IL	0.978	0.925	1.137
621	11	DECATUR, IL	0.981	0.927	1.137
621	12	EAST ST. LOUIS, IL	0.989	0.958	1.579
621	6	KANKAKEE, IL	0.972	0.925	1.137
621	8	NORMAL, IL	0.997	0.968	1.137
621	1	NORTHWEST, IL	0.974	0.896	1.137
621	5	PEORIA, IL	1.009	1.031	1.137
621	7	QUINCY, IL	0.974	0.896	1.137
621	4	ROCK ISLAND, IL	0.995	0.958	1.137
621	2	ROCKFORD, IL	1.010	1.018	1.137
621	13	SOUTHEAST IL	0.974	0.896	1.137
621	14	SOUTHERN IL	0.974	0.896	1.137
621	9	SPRINGFIELD, IL	0.996	0.966	1.137
621	15	SUBURBAN CHICAGO, IL	1.020	1.097	1.137
630	1	METROPOLITAN INDIANA	0.998	0.963	0.547
630	3	REST OF INDIANA	0.979	0.896	0.516
630	2	URBAN INDIANA	0.980	0.905	0.516
640	5	DES MOINES(POLK/WARREN),IA	0.997	0.966	0.666
640	3	NORTH CENTRAL IOWA	0.971	0.916	0.666
640	2	NORTHEAST IOWA	0.972	0.918	0.666
640	6	NORTHWEST IOWA	0.969	0.890	0.666
640	4	S.CEN. IA(EXCL DES MOINES)	0.962	0.881	0.666
640	1	SE IOWA (INCL IOWA CITY)	0.976	0.933	0.666
640	7	SOUTHWEST IOWA	0.968	0.900	0.666
740	5	KANSAS CITY, KS	0.978	0.964	1.134
650	1	REST OF KANSAS	0.953	0.893	1.134
740	4	SUBURBAN KANSAS CITY, KS	0.978	0.964	1.134

ADDENDUM C

TABLE 1

GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER LOCALITY

(continued)

CARRIER NUMBER	LOCALITY NUMBER	LOCALITY NAME	WORK	PRACTICE EXPENSE	MAL- PRACTICE
660	1	LEXINGTON & LOUISVILLE, KY	0.984	0.917	0.667
660	3	REST OF KENTUCKY	0.974	0.875	0.667
660	2	SM CITIES (CITY LIMITS) KY	0.976	0.898	0.667
528	7	ALEXANDRIA, LA	0.985	0.889	0.808
528	3	BATON ROUGE, LA	0.991	0.966	0.808
528	6	LAFAYETTE, LA	0.982	0.928	0.808
528	4	LAKE CHARLES, LA	0.975	0.907	0.808
528	5	MONROE, LA	0.979	0.880	0.808
528	1	NEW ORLEANS, LA	0.994	1.003	1.185
528	50	REST OF LOUISIANA	0.972	0.880	0.824
528	2	SHREVEPORT, LA	1.003	0.940	0.808
21200	2	CENTRAL MAINE	0.942	0.903	0.716
21200	1	NORTHERN MAINE	0.947	0.912	0.716
21200	3	SOUTHERN MAINE	0.956	0.980	0.716
690	1	BALTIMORE/SURR. CNTYS, MD	1.027	1.040	0.927
690	3	SOUTH + E. SHORE MD	1.011	1.010	0.820
690	2	WESTERN MARYLAND	1.006	1.013	0.843
700	2	MASS.SUBURBS/RURAL(CITIES)	0.997	1.072	0.855
700	1	MASSACHUSETTS URBAN	1.002	1.131	0.855
710	1	DETROIT, MI	1.059	1.091	1.736
710	2	MICHIGAN, NOT DETROIT	1.010	0.971	1.196
720	00	MINNESOTA (BLUE SHIELD)	0.999	0.971	0.748
10240	00	MINNESOTA (TRAVELERS)	0.999	0.971	0.748
10250	1	REST OF MISSISSIPPI	0.960	0.838	0.650
10250	2	URBAN MS (CITY LIMITS)	0.966	0.902	0.650
740	3	K.C. (JACKSON COUNTY), MO	0.978	0.964	1.179
740	2	N. K.C. (CLAY/PLATTE), MO	0.978	0.964	1.179
11260	3	REST OF MO	0.950	0.847	1.179
740	6	RURAL NW COUNTIES, MO	0.953	0.866	1.179
11260	2	SM. E.CITIES, MO	0.954	0.838	1.179
740	1	ST. JOSEPH, MO	0.950	0.867	1.179
11260	1	ST. LOUIS/LG. E.CITIES, MO	0.988	0.964	1.352
751	1	MONTANA	0.967	0.926	0.718
655	00	NEBRASKA	0.960	0.883	0.435
1290	3	ELKO & ELY (CITIES), NV	0.984	1.026	1.144
1290	1	LAS VEGAS, ET AL (CITIES), NV	1.036	1.082	1.144
1290	2	RENO, ET AL (CITIES), NV	1.008	1.141	1.144
1290	99	REST OF NEVADA	1.020	1.079	1.144
780	40	NEW HAMPSHIRE	0.962	1.011	0.602
860	2	MIDDLE NEW JERSEY	1.034	1.070	1.153
860	1	NORTHERN NEW JERSEY	1.040	1.131	1.153
860	3	SOUTHERN NEW JERSEY	1.016	1.030	1.153
1360	5	NEW MEXICO	0.981	0.925	0.767
801	1	BUFFALO/SURR. CNTYS, NY	1.006	0.942	0.963
803	1	MANHATTAN, NY	1.059	1.255	1.647

ADDENDUM C
TABLE 1

GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER LOCALITY

(continued)

CARRIER NUMBER	LOCALITY NUMBER	LOCALITY NAME	WORK	PRACTICE EXPENSE	MAL- PRACTICE
801	3	N. CENTRAL CITIES, NY	0.997	0.952	0.963
803	2	NYC SUBURBS/LONG I., NY	1.060	1.229	1.929
803	3	POUGHKPSIE/N.NYC SUBURBS	1.004	1.018	1.325
14330	4	QUEENS, NY	1.059	1.255	1.861
801	2	ROCHESTER/SURR. CNTYS, NY	1.021	1.017	0.963
801	4	REST OF NEW YORK	0.988	0.935	0.963
5535	95	REST OF NORTH CAROLINA	0.963	0.883	0.378
5535	94	URBAN (CITY LIMITS) NC	0.975	0.926	0.378
820	1	NORTH DAKOTA	0.965	0.895	0.688
16360	1	AKRON, OH	0.993	0.944	0.920
16360	2	CINCINNATI, OH	0.989	0.956	0.920
16360	3	CLEVELAND, OH	1.011	0.968	0.920
16360	4	COLUMBUS, OH	0.983	0.956	0.920
16360	5	DAYTON, OH	0.999	0.935	0.920
16360	9	E. CENTRAL (STEUBENVL), OH	0.974	0.912	0.920
16360	7	MANSFIELD, OH	0.972	0.906	0.920
16360	13	MARION + SURR. CNTYS., OH	0.971	0.911	0.920
16360	6	NORTHWEST (LIMA) OH	0.973	0.919	0.920
16360	14	SCIOTO VALLEY, OH	0.977	0.936	0.920
16360	15	SOUTHEAST (OHIO VALLEY) OH	0.973	0.909	0.920
16360	8	SPRINGFIELD, OH	1.004	0.940	0.920
16360	10	TOLEDO (LUCAS/WOOD), OH	0.991	0.996	0.920
16360	12	W. CENTR (LAKE PLAINS), OH	0.969	0.906	0.920
16360	11	YOUNGSTOWN, OH	0.987	0.937	0.920
1370	00	OKLAHOMA	0.969	0.911	0.516
1380	2	EUGENE, ET AL (CITIES), OR	0.968	1.008	0.951
1380	1	PORTLAND, ET AL (CITIES), OR	0.993	1.033	0.951
1380	99	REST OF OREGON	0.979	0.997	0.951
1380	3	SALEM, ET AL (CITIES), OR	0.974	0.990	0.951
1380	12	SW OR. CITIES(CITY LIMITS)	0.974	0.988	0.951
865	2	LG. PENNSYLVANIA CITIES	1.008	1.001	1.440
865	1	PHILLY/PITT MED SCHS/HOSPS	1.014	1.014	1.552
865	4	REST OF PENNSYLVANIA	0.975	0.929	0.986
865	3	SMALL PENNSYLVANIA CITIES	0.984	0.945	0.986
973	20	PUERTO RICO	0.882	0.763	0.466
870	1	RHODE ISLAND	1.009	0.998	0.734
880	1	SOUTH CAROLINA	0.971	0.874	0.448
820	2	SOUTH DAKOTA	0.951	0.857	0.688
5440	35	TENNESSEE	0.969	0.896	0.407
900	29	ABILENE, TX	0.971	0.888	0.504
900	26	AMARILLO, TX	0.972	0.900	0.504
900	31	AUSTIN, TX	0.969	0.968	0.504
900	20	BEAUMONT, TX	0.998	0.955	0.504
900	9	BRAZORIA, TX	1.025	0.955	0.504
900	10	BROWNSVILLE, TX	0.980	0.888	0.504

ADDENDUM C

TABLE 1

GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER LOCALITY

(continued)

CARRIER NUMBER	LOCALITY NUMBER	LOCALITY NAME	WORK	PRACTICE EXPENSE	MAL- PRACTICE
900	24	CORPUS CHRISTI, TX	0.976	0.944	0.504
900	11	DALLAS, TX	0.996	0.971	0.504
900	12	DENTON, TX	0.996	0.971	0.504
900	14	EL PASO, TX	0.995	0.894	0.504
900	28	FORT WORTH, TX	0.973	0.936	0.504
900	15	GALVESTON, TX	0.982	0.968	0.504
900	16	GRAYSON, TX	0.964	0.903	0.504
900	18	HOUSTON, TX	1.014	0.982	0.656
900	33	LAREDO, TX	0.968	0.856	0.504
900	17	LONGVIEW, TX	0.968	0.929	0.504
900	21	LUBBOCK, TX	0.950	0.881	0.504
900	19	MC ALLEN, TX	0.945	0.873	0.504
900	23	MIDLAND, TX	1.023	0.998	0.504
900	2	NORTHEAST RURAL TEXAS	0.968	0.883	0.504
900	13	ODESSA, TX	1.008	0.971	0.504
900	25	ORANGE, TX	0.998	0.955	0.504
900	30	SAN ANGELO, TX	0.954	0.902	0.504
900	7	SAN ANTONIO, TX	0.973	0.929	0.504
900	3	SOUTHEAST RURAL TEXAS	0.973	0.895	0.504
900	6	TEMPLE, TX	0.969	0.886	0.504
900	8	TEXARKANA, TX	0.953	0.883	0.504
900	27	TYLER, TX	0.984	0.931	0.504
900	32	VICTORIA, TX	0.976	0.973	0.504
900	22	WACO, TX	0.981	0.871	0.504
900	4	WESTERN RURAL TEXAS	0.961	0.852	0.504
900	34	WICHITA FALLS, TX	0.969	0.896	0.504
910	9	UTAH	0.993	0.952	0.739
780	50	VERMONT	0.942	0.941	0.533
10490	1	RICHMOND+CHARLOTTESVL, VA	0.975	0.953	0.462
10490	4	REST OF VIRGINIA	0.967	0.888	0.522
10490	3	SM. TOWN/INDUSTRIAL VA	0.971	0.892	0.531
10490	2	TIDEWATER+N. VA COUNTIES	0.989	0.994	0.703
973	50	VIRGIN ISLANDS	1.000	1.000	1.000
932	4	E.CEN+NE WA (EXCL SPOKANE)	0.991	0.979	1.064
932	2	SEATTLE (KING CNTY), WA	1.019	1.049	1.064
932	3	SPOKANE+RICHLND(CITIES), WA	0.996	0.995	1.064
932	1	W + SE WA (EXCL SEATTLE)	1.008	0.992	1.064
16510	16	CHARLESTON, WV	0.987	0.962	0.688
16510	18	EASTERN VALLEY, WV	0.962	0.881	0.688
16510	19	OHIO RIVER VALLEY, WV	0.962	0.881	0.688
16510	20	SOUTHERN VALLEY, WV	0.960	0.876	0.688
16510	17	WHEELING, WV	0.975	0.900	0.688
951	13	CENTRAL WISCONSIN	0.960	0.888	0.762
951	40	GREEN BAY, WI (NORTHEAST)	0.979	0.913	0.762
951	54	JANESVILLE, WI (S-CENTRAL)	0.970	0.905	0.762

ADDENDUM C

TABLE 1

GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER LOCALITY

(continued)

CARRIER NUMBER	LOCALITY NUMBER	LOCALITY NAME	WORK	PRACTICE EXPENSE	MAL- PRACTICE
951	19	LA CROSSE, WI (W-CENTRAL)	0.976	0.919	0.762
951	15	MADISON, WI (DANE COUNTY)	0.977	0.979	0.762
951	46	MILWAUKEE SUBURBS, WI (SE)	1.010	1.008	0.762
951	4	MILWAUKEE, WI	1.008	1.009	0.762
951	12	NORTHWEST WISCONSIN	0.966	0.898	0.762
951	60	OSHKOSH, WI (E-CENTRAL)	0.974	0.911	0.762
951	14	SOUTHWEST WISCONSIN	0.960	0.888	0.762
951	36	WAUSAU, WI (N-CENTRAL)	0.971	0.898	0.762
825	21	WYOMING	0.988	0.938	0.641

Note: Work GPCI is the 1/4 work GPCI required by Pub. L. 101-239.

TABLE 2.—CHANGES IN GPCIS FROM PROPOSED RULE

Carrier	Locality	Change from proposed rule
640	1 & 8	Locality 8 was combined with Locality 1. The GPCIs for Locality 1 were changed to reflect the combination of localities 1 and 8. (Locality 8 was a teaching hospital.) GPCIs for Locality 1 changed from: Work—0.978 to 0.976 Practice expense—0.929 to 0.933 Malpractice—No change
720 10240	2 & 4 1	Minnesota has become Statewide for payment purposes. Both carriers are still identified (720 and 10240), but they both have the same locality number—"00", and they both have the same Statewide GPCIs. Statewide GPCIs Work—0.999 Practice expense—0.971 Malpractice—0.748
5530	21	Wyoming carrier number was changed from 5530 to 825.
11260	2	Locality name for Locality 2 was changed to exclude Jefferson County, which is actually in Locality 1. Both localities have new GPCIs to reflect this correction of moving Jefferson County from Locality 2 to Locality 1. Work GPCI changed from 0.973 to 0.954. Practice expense GPCI changed from 0.907 to 0.838.
11260	1	Practice expense GPCI changed from 0.963 to 0.964. Malpractice GPCI changed from 1.366 to 1.352.
655	15, 16, 17	Nebraska has become a Statewide locality. The locality codes have been changed to a Statewide locality—"00", and the GPCIs have been changed to Statewide GPCIs. Statewide GPCIs Work—0.960 Practice expense—0.883 Malpractice—0.435
1360	1	Locality number 1 was changed to Locality number 5. (No change to the GPCIs.)
1370	1, 2, 3, 4, 99	Oklahoma has become a Statewide locality. The locality codes have been changed to a Statewide locality—"00", and the GPCIs have been changed to Statewide GPCIs. Statewide GPCIs Work—0.969 Practice expense—0.911 Malpractice—0.516

The following changes reflect corrections in county to locality assignments.

1380	3	Practice expense GPCI change from 0.991 to 0.990.
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TABLE 2.—CHANGES IN GPCIS FROM PROPOSED RULE—Continued

Carrier	Locality	Change from proposed rule
865	2	Work GPCI changed from 1.007 to 1.008. Malpractice GPCI changed from 1.433 to 1.440.
865	3	Practice expense GPCI changed from 0.941 to 0.945.
865	4	Work GPCI changed from 0.976 to 0.975. Practice expense changed from 0.935 to 0.929.
900	2	Work GPCI changed from 0.969 to 0.968. Practice expense GPCI changed from 0.884 to 0.883.
900	3	Practice expense GPCI changed from 0.894 to 0.895.
930	3	Washington carrier number was changed from 930 to 932. In addition, the Work GPCI changed from 0.997 to 0.996. Practice expense GPCI changed from 0.997 to 0.995.
951	19	Work GPCI changed from 0.974 to 0.976. Practice expense GPCI changed from 0.922 to 0.919.
951	12	Work GPCI changed from 0.970 to 0.966.

Addendum D—Information for Obtaining Sources of Data Underlying Physician Fee Schedule

A. NTIS/GPO Documents

National Technical Information Service (NTIS); phone 1-800-336-4700; or (703) 487-4650; Springfield, Va 22161.

Government Printing Office (GPO); phone (202) 512-2465 for orders, (202) 275-3050 for service inquiries; (202) 275-3054 for complaints; mail to Superintendent of Documents, U.S.G.P.O., Washington, DC 20402.

- Harvard Phase I Volumes; NTIS; Volume I, Executive Summary, PB89-101828
- Volume II, Data description and analysis, PB89-101836
- Volume III, Results and conclusions for surveyed procedures, PB89-101844
- Volume IV, Copies of surveys and other information, PB89-101851
- Volume IVA, Visit and consultation methodology and results, PB89-164412
- Volume V, Documentation for the data tape, PB89-101869
- Volume VI, Final values and components, PB89-164420
- Survey data tape (including Volume IV and Volume V documentation) PB89-101810
- Phase I final values data tape, PB89-164404
- Harvard Phase II Volumes; NTIS;

Volume I, Executive Summary, PB91-172189

Volume II, Final Report, PB91-172197

Volume III, Appendices, PB91-172205

Volume IV, Data Files Documentation, PB91-172213

Volume V, Data Files (paper copy), PB91-172221

Data Files (diskette), PB91-507251

Five-volume Set, PB91-172171

3. October 1989 Reports to Congress "Medicare Physician Payment" (HCFA Pub. No. 03287); composed of three reports:

—"Volume and Intensity of Physician Services"

—"Relative Value Scales for Physician Services" and

—"Implementation of a National Fee Schedule"

NTIS accession # PB90-148370

GPO stock number 017-060-00314-6

4. Center for Health Economics Research (CHER) report on "Geographic Variation in Surgical Fees," NTIS PB90-122466.

5. Center for Health Economics Research (CHER) report on "Global Fees for Surgery," NTIS PB91-113498

6. Urban Institute GPCI report "The Geographic Medicare Index: Alternative Approaches," NTIS PB89-216592.

Supplement to "The Geographic Medicare Index: Alternative Approaches," Tuesday, September 4, 1990, *Federal Register*, Vol. 55, No. 171; NTIS PB91-113506.

7. Urban Institute Report "Refining the Malpractice Geographic Practice Cost Index," February 1991; NTIS PB91-155218.

Personal computer diskette (tables and documentation); NTIS PB91-506899.

8. "Model Fee Schedule," Tuesday, September 4, 1990, *Federal Register*, Vol. 55, No. 171.

GPO stock number 069-001-00023-8

B. Documents from Other Sources

1. Physician Payment Review Commission Visit Coding Recommendations—

Physician Payment Review Commission, 2120 L Street, NW., Suite 510, Washington, DC 20037

2. Harvard Phase II Study for Dermatology Services—

American Academy of Dermatology, 1567 Maple Avenue, P.O. Box 3116, Evanston, Illinois 60204-3116, Phone: (708) 869-4382

Attention: Raymond W. Harrington, Jr., Assistant Executive Director, Division of Health Policy and Public Affairs

3. Harvard Phase II Study for Pathology Services—

College of American Pathologists, 1101 Vermont Avenue, NW, Suite 604, Washington, DC 20005, Phone: (202) 371-6617

Attention: Professional Relations

4. Harvard Phase II Study for Psychiatry Services (Contract 278-87-0024, NTIS accession number pending)—

National Institute of Mental Health, Division of Applied and Services Research, 5600 Fishers Lane, Room 18-C-14, Rockville, Maryland 20857, Phone: (301) 443-4233

Attention: Paul Widem

5. Harvard Phase II Study for Ophthalmology Services—

American Academy of Ophthalmology, 1101 Vermont Avenue, NW, Suite 300, Washington, DC 20005, Phone: (202) 737-6662

Attention: Stephanie Mensh, Assistant Director for Federal Economic Policy

Addendum E—AMA Evaluation and Management Codes

Physician's Current Procedural Terminology, fourth Edition, Copyright 1991 by the American Medical Association ("CPT-1992") is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians. Like all CPT codes, these CPT codes for reporting evaluation and management services are copyrighted by the AMA and are used by HCFA under the terms of its agreement with the AMA. The AMA's CPT codes are reviewed each year by the AMA's CPT Editorial Panel. As such, the visit codes presented here are subject to revision, if necessary, by the AMA CPT Editorial Panel in 1993. The codes are presented here with the permission of the AMA as a convenience to physicians. Reproduction of them without the permission of the American Medical Association is a violation of copyright laws. HCFA is not requesting or accepting comment on these visit code definitions. Any comments on the evaluation and management codes should be addressed to the Department of Coding and Nomenclature, American Medical Association, 515 North State Street, Chicago, Illinois 60610.

Clinical examples of the new CPT codes for E/M services are intended to be an important element of the new coding system. The clinical examples, when used with the revised E/M descriptors and time guidelines provide a new tool for physicians to use to determine the appropriate code for the services provided to their patients.

Unfortunately, at the time of publication of the codes, the

development and validation of clinical examples had not been completed. An initial set of these examples (for office/other outpatient services, inpatient services, consultations) will however, be completed and made available to physicians prior to the effective date of the new E/M codes. Subscribers to CPT Assistant will receive these examples automatically. Others may obtain them from AMA upon written request, or through Medicare carriers.

Clinical examples will continue to be developed and evaluated throughout the year. A complete set of examples will be published along with the E/M codes and time guidelines in *CPT 1993*.

The full text of the *CPT 1992* is available from the American Medical Association. Newly developed clinical examples, and additional clarifications to the coding guidelines will be published as necessary in the *CPT Assistant*, also available from AMA. Phone: AMA 1-800-621-8335.

Evaluation and Management (E/M) Services

The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, e.g., office consultation. Third, the content of the service is defined, e.g., comprehensive history and comprehensive examination. (See levels of E/M services below for details on the content of E/M services.) Fourth, the nature of the presenting problem(s) usually associated with a given level is described. Fifth, the time typically required to provide the service is specified.

Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians in differing specialties.

History: The levels of E/M services recognize four types of history that are defined as follows:

- Problem Focused—chief complaint; brief history of present illness or problem.
- Expanded Problem Focused—chief complaint; brief history of present illness; problem pertinent system review.
- Detailed—chief complaint; extended history of present illness; extended system review; pertinent past, family and/or social history.
- Comprehensive—chief complaint; extended history of present illness; complete system review; complete past, family and social history.

Examination: The levels of E/M services recognize four types of examination that are defined as follows:

- Problem Focused—an examination that is limited to the affected body area or organ system.
 - Expanded Problem Focused—an examination of the affected body area or organ system and other symptomatic or related organ systems.
 - Detailed—an extended examination of the affected body area(s) and other symptomatic or related organ system(s).
 - Comprehensive—a complete single system specialty examination or a complete multi-system examination.
- Medical Decision Making:** Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:
- The number of possible diagnoses and/or the number of management options that must be considered;
 - The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
 - The risk of significant complications, morbidity and/or mortality, as well as co-morbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

Four types of medical decision making are recognized: straightforward; low complexity; moderate complexity; and, high complexity.

Counseling: Counseling is a discussion with a patient and/or family concerning one or more of the following areas:

- Diagnostic results, impressions, and/or recommended diagnostic studies;
- Prognosis;
- Risks and benefits of management (treatment) options;
- Instructions for management (treatment) and/or follow-up;
- Importance of compliance with chosen management (treatment) options;
- Risk factor reduction; and
- Patient and family education.

Time: The inclusion of time as an explicit factor is done to assist physicians in selecting the most appropriate level of E/M services. It should be recognized that the specific times expressed in the visit code descriptors are averages, and therefore represent a range of times which may be higher or lower depending on actual clinical circumstances.

Intra-service times are defined as face-to-face time for office and other outpatient visits and as unit/floor time for hospital and other inpatient visits. This distinction is necessary because

most of the work of typical office visits takes place during the face-to-face time with the patient, while most of the work of typical hospital visits takes place during the time spent on the patient's floor or unit.

Office or Other Outpatient Services

The following codes are used to report evaluation/management services provided in the physician's office or in an outpatient or other ambulatory facility. A patient is considered an outpatient until inpatient admission to a health care facility occurs.

To report services provided to a patient who is admitted to a hospital or nursing facility in the course of an encounter in the office or other ambulatory facility, see the notes for initial hospital inpatient care or comprehensive nursing facility assessments.

For services provided by physicians in the Emergency Department, see 99281-99285.

The codes for office and other outpatient services are also used to report the services provided by a physician to a patient in an observation area of a hospital.

New Patient

99201 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- A problem focused history;
- A problem focused examination; and
- Straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- An expanded problem focused history;
- An expanded problem focused examination; and
- Straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low to moderate severity. Physicians

typically spend 20 minutes face-to-face with the patient and/or family.

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- A detailed history;
- A detailed examination; and
- Medical decision making of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- A comprehensive history;
- A comprehensive examination; and
- Medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- A comprehensive history;
- A comprehensive examination; and
- Medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

Established Patient

The following codes are used to report the evaluation/management services provided to established patients who present for follow-up and/or periodic reevaluation of problems or for the evaluation and management of new problem(s) in established patients.

99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician.

Usually, the presenting problem(s) are minimal.

Typically, 5 minutes are spent performing or supervising these services.

99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- A problem focused history;
- A problem focused examination;
- Straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- An expanded problem focused history;
- An expanded problem focused examination; and
- Medical decision making of low complexity.

Counseling and coordination of care are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- A detailed history;
- A detailed examination;
- Medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- A comprehensive history;
- A comprehensive examination;
- Medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

Hospital Inpatient Services

The following codes are used to report evaluation and management services provided to hospital inpatients. Hospital inpatient services include those services provided to patients in a 'partial hospital' setting. These codes are to be used to report these partial hospitalization services. See also psychiatry notes.

For definitions of key components and commonly used terms, please see evaluation and management services guidelines.

Initial Hospital Care

New or Established Patient

The following codes are used to report the first hospital inpatient encounter with the patient by the admitting physician. For initial inpatient encounters by physicians other than the admitting physician, see initial inpatient consultation codes (99251-99255) or subsequent hospital care codes (99231-99233) as appropriate.

When the patient is admitted to the hospital in the course of an encounter in another site of service (eg, hospital emergency department, physician's office, nursing facility) all evaluation/management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission. The inpatient care level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of service as well as in the inpatient setting. Evaluation/management services on the same date provided in sites other than the hospital that are related to the admission should NOT be reported separately.

99221 Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components:

- A comprehensive history;
- A comprehensive examination; and
- Medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at

the bedside and on the patient's hospital floor or unit.

99222 Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components:

- A comprehensive history;
- A comprehensive examination; and
- Medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

99223 Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components:

- A comprehensive history;
- A comprehensive examination; and
- Medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

Subsequent Hospital Care

All levels of subsequent hospital care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status, (i.e., changes in history, physical condition and response to management) since the last assessment by the physician.

99231 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:

- A problem focused interval history;
- A problem focused examination; and
- Medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

99232 Subsequent hospital care, per day, for the evaluation and management

of a patient, which requires at least two of these three key components:

- An expanded problem focused interval history;
- An expanded problem focused examination;
- Medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and/or on the patient's hospital floor or unit.

99233 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:

- A detailed interval history;
- A detailed examination;
- Medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

Hospital Discharge Services

Final Hospital care for discharge of a patient includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records. (Final day of a multiple day stay)

99238 Hospital discharge day management.

(To report services to a patient who is admitted as an inpatient and discharged on the same day, use only the appropriate code for Initial Hospital Inpatient Services, 99221-99223.)

Consultations

A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.

A physician consultant may initiate diagnostic and/or therapeutic services.

The request for a consultation from the attending physician or other appropriate source and the need for consultation must be documented in the

patient's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated to the requesting physician or other appropriate source.

A "consultation" initiated by a patient and/or family, and not requested by a physician, is not reported using the initial consultation codes but may be reported using the codes for confirmatory consultation or office visits, as appropriate. If a confirmatory consultation is required, e.g., by a third party payor, the modifier -32 or 09932, mandated services, should also be reported.

Any specifically identifiable procedure (i.e., identified with a specific CPT code) performed on or subsequent to the date of the initial consultation should be reported separately.

If a consultant subsequently assumes responsibility for management of a portion or all of the patient's condition(s), the consultation codes should not be used. In the hospital setting, the physician receiving the patient for partial or complete transfer of care should use the appropriate subsequent hospital care codes. In the office setting, the appropriate established patient code should be used.

There are four sub-categories of consultations: office, initial inpatient, follow-up inpatient, and confirmatory. See each sub-category for specific reporting instructions.

For definitions of key components and commonly used terms, please see Evaluation and Management Services Guidelines.

Office and Other Outpatient Consultations

New or Established Patient

The following codes are used to report consultations provided in the physician's office or in an outpatient or other ambulatory facility, including an emergency department. (See consultation definition).

Follow-up visits in the consultant's office or other outpatient facility that are initiated by the physician consultant are reported using office visit codes for established patients (see 99211-99215). If an additional request for an opinion or advice regarding the same or a new problem is received from the attending physician and documented in the medical record, the office consultation codes may be used again.

99241 Office consultation for a new or established patient, which requires these three key components:

- A problem focused history;

- A problem focused examination; and
- Straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99242 Office consultation for a new or established patient, which requires these three key components:

- An expanded problem focused history;
- An expanded problem focused examination; and
- Straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

99243 Office consultation for a new or established patient, which requires these three key components:

- A detailed history;
- A detailed examination; and
- Medical decision making of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

99244 Office consultation for a new or established patient, which requires these three key components:

- A comprehensive history;
- A comprehensive examination; and
- Medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

99245 Office consultation for a new or established patient, which requires these three key components:

- A comprehensive history;
- A comprehensive examination; and

- Medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.

Initial Inpatient Consultations

New or Established Patient

The following codes are used to report physician consultations provided to hospital inpatients or residents of nursing facilities. Only one initial consultation should be reported by a consultant per admission.

99251 Initial inpatient consultation for a new or established patient, which requires these three key components:

- A problem focused history;
- A problem focused examination; and
- Straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.

99252 Initial inpatient consultation for a new or established patient, which requires these three key components:

- An expanded problem focused history;
- An expanded problem focused examination; and
- Straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low severity. Physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit.

99253 Initial inpatient consultation for a new or established patient, which requires these three key components:

- A detailed history;
- A detailed examination; and
- Medical decision making of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature

of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 55 minutes at the bedside and on the patient's hospital floor or unit.

99254 Initial inpatient consultation for a new or established patient, which requires three key components:

- A comprehensive history;
- A comprehensive examination; and
- Medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes at the bedside and on the patient's hospital floor or unit.

99255 Initial inpatient consultation for a new or established patient, which requires these three key components:

- A comprehensive history;
- A comprehensive examination; and
- Medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 110 minutes at the bedside and on the patient's hospital floor or unit.

Follow-up Inpatient Consultations Established Patient

Follow-up consultations are visits to complete the initial consultation OR subsequent consultative visits requested by the attending physician. A follow-up consultation includes monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the patient's status.

If the physician consultant has initiated treatment at the initial consultation, and participates thereafter in the patient's management, the codes for subsequent hospital care should be used (see 99231-99233).

The following codes are used to report follow-up consultations provided to hospital inpatients or nursing facility residents only. For consultative services provided in other settings, the codes for office or other outpatient consultations should be reported (see 99241-99245).

99261 Follow-up inpatient consultation for an established patient,

which requires at least two of these three key components:

- A problem focused interval history;
- A problem focused examination; and

• Medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving. Physicians typically spend 10 minutes at the bedside and on the patient's hospital floor or unit.

99262 Follow-up inpatient consultation for an established patient which requires at least two of these three key components:

- An expanded problem focused interval history;
- An expanded problem focused examination; and
- Medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.

99263 Follow-up inpatient consultation for an established patient which requires at least two of these three key components:

- A detailed interval history;
- A detailed examination; and
- Medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

Confirmatory Consultations New or Established Patient

The following codes are used to report the evaluation/ management services provided to patients when the consulting physician is aware of the confirmatory nature of the opinion sought (eg, when a second/third opinion is requested or required on the necessity or appropriateness of a previously

recommended medical treatment or surgical procedure). Confirmatory consultations may be provided in any setting.

A physician consultant providing a confirmatory consultation is expected to provide an opinion and/or advice only. Any services subsequent to the opinion are coded at the appropriate level of office visit, established patient, or subsequent hospital care. If a confirmatory consultation is required, e.g., by a third party payor, the modifier -32 or 00932, mandated services, should be also reported.

(See also Consultation Notes)

Typical times have not been established for this sub-category of services.

99271 Confirmatory consultation for a new or established patient, which requires these three key components:

- A problem focused history;
- A problem focused examination; and
- Straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self limited or minor.

99272 Confirmatory consultation for a new or established patient, which requires these three key components:

- An expanded problem focused history;
- An expanded problem focused examination; and
- Straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low severity.

99273 Confirmatory consultation for a new or established patient, which requires these three key components:

- A detailed history;
- A detailed examination; and
- Medical decision making of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate severity.

99274 Confirmatory consultation for a patient, which requires these three key components:

- A comprehensive history;

- A comprehensive examination; and
- Medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity.

99275 Confirmatory consultation for a patient, which requires these three key components:

- A comprehensive history;
- A comprehensive examination; and
- Medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity.

Emergency Department Services

New or Established Patient

The following codes are used to report evaluation/management services provided in the emergency department. No distinction is made between new and established patients in the emergency department.

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.

For critical care services provided in the Emergency Department, see critical care notes and 99291-99292.

For evaluation/management services provided to a patient in an observation area of a hospital see 99201-99215.

For definitions of key components and commonly used terms, please see Evaluation and Management Services Guidelines.

99281 Emergency department visit for the evaluation and management of a patient, which requires these three key components:

- A problem focused history;
- A problem focused examination; and
- Straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self limited or minor.

99282 Emergency department visit for the evaluation and management of a

patient, which requires these three key components:

- An expanded problem focused history;
- An expanded problem focused examination; and
- Medical decision making of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low to moderate severity.

99283 Emergency department visit for the evaluation and management of a patient, which requires these three key components:

- An expanded problem focused history;
- An expanded problem focused examination; and
- Medical decision making of low to moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate severity.

99284 Emergency department visit for the evaluation and management of a patient, which requires these three key components:

- A detailed history;
- A detailed examination; and
- Medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.

99285 Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and mental status:

- A comprehensive history;
- A comprehensive examination; and
- Medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

Miscellaneous

In physician directed emergency care, advanced life support, the physician is located in a hospital emergency or critical care department, and is in two-way voice communication with ambulance or personnel outside the hospital. The physician directs the performance of necessary medical procedures, including but not limited to: telemetry of cardiac rhythm; cardiac and/or pulmonary resuscitation; endotracheal or esophageal obturator airway intubation; administration of intravenous fluids and/or administration of intramuscular, intratracheal or subcutaneous drugs; and/or electrical conversion of arrhythmia.

99288 Physician direction of emergency medical systems (EMS) emergency care, advanced life support.

Critical Care Services

Critical care includes the care of critically ill patients in a variety of medical emergencies that requires the constant attention of the physician (e.g., cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, critically ill neonate). Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility. The descriptors for critical care are intended to include cardiopulmonary resuscitation and a variety of services attendant to this procedure as well as other acute emergency situations. Services for a patient who is not critically ill but happens to be in a critical care unit are reported using subsequent hospital care codes. (See 99231-99233.)

Services performed during the critical period (e.g., placement of catheters, cardiac output measurement, tube thoracostomy, control of gastrointestinal hemorrhage, electrical conversion of arrhythmia, endotracheal intubation, management of mechanical ventilation, blood gas monitoring) are included in the report 99291, 99292.

The critical care codes are used to report the total duration of time spent by a physician providing constant attention to a critically ill patient. Code 99291 is used to report the first hour of critical care on a given day. It should be used only once per day even if the time spent by the physician is not continuous on that day. Code 99292 is used to report each additional 30 minutes beyond the first hour. For example, if 1 hour of critical care is provided at 10AM and 2 hours provided from 3PM to 5PM, then

report code 99291 once and 99292 four times to report the total of three hours on a single day.

Other procedures which are not directly attendant to critical care management (e.g., the suturing of lacerations, setting of fractures, reduction of joint dislocations, lumbar puncture, peritoneal lavage, bladder tap) are not included in critical care and should be reported separately.

99291 Critical care, including the diagnostic and therapeutic services and direction of care of the critically ill or multiply injured or comatose patient, requiring the prolonged presence of the physician; first hour.

99292 Each additional 30 minutes.

Nursing Facility Services

The following codes are used to report evaluation/management services to patients in Nursing Facilities (formerly called Skilled Nursing Facilities (SNFs), Intermediate Care Facilities (ICFs) or Long Term Care Facilities (LTCFs)).

These codes should also be used to report evaluation and management services provided to a patient in a psychiatric residential treatment center (a facility or a distinct part of a facility for psychiatric care, which provides a 24 hour therapeutically planned and professionally staffed group living and learning environment). If procedures such as medical psychotherapy are provided in addition to evaluation and management services, these should be reported in addition to the evaluation and management services provided.

Nursing facilities that provide convalescent, rehabilitative, or long term care are required to conduct comprehensive, accurate, standardized, and reproducible assessments of each resident's functional capacity using a Resident Assessment Instrument (RAI). All RAIs include the Minimum Data Set (MDS), Resident Assessment Protocols (RAPs) and utilization guidelines. The MDS is the primary screening and assessment tool; the RAPs specify triggers that identify potential problems and provide guidelines for follow-up assessments.

Physicians have a central role in assuring that all residents receive thorough assessments and that medical plans of care are instituted or revised to enhance or maintain the residents' physical and psychosocial functioning.

Two sub-categories of nursing facility services are recognized: Comprehensive Nursing Facility Assessments and Subsequent Nursing Facility Care. Both sub-categories apply to new or established patients. Comprehensive Assessments may be performed at one or more sites in the assessment process:

the hospital, office, nursing facility, domiciliary/non-nursing facility or patient's home.

For definitions of key components and commonly used terms, please see Evaluation and Management Services Guidelines.

Comprehensive Nursing Facility Assessments

New or Established Patient

When the patient is admitted to the nursing facility in the course of an encounter in another site of service (e.g., hospital emergency department, physician's office), all evaluation/management services provided by that physician in conjunction with that admission are considered part of the initial nursing facility care when performed on the same date as the admission. The nursing facility care level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of service as well in the nursing facility setting. With the exception of hospital discharge services, evaluation/management services on the same date provided in sites other than the nursing facility that are related to the admission should NOT be reported separately. Hospital discharge services may be reported separately.

More than one comprehensive assessment may be necessary during an inpatient confinement.

99301 Evaluation and management of a new or established patient involving an annual nursing facility assessment which requires these three key components:

- A detailed interval history;
- A comprehensive examination; and
- Medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving. The review and affirmation of the medical plan of care is required.

Physicians typically spend 30 minutes at the bedside and on the patient's facility floor or unit.

99302 Evaluation and management of a new or established patient involving a nursing facility assessment which requires these three key components:

- A detailed interval history;
- A comprehensive examination; and
- Medical decision making of moderate to high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient has developed a significant complication or a significant new problem and has had a major permanent change in status. The creation of a new medical plan of care is required.

Physicians typically spend 40 minutes at the bedside and on the patient's facility floor or unit.

99303 Evaluation and management of a new or established patient involving a nursing facility assessment at the time of initial admission to the facility, which requires these three key components:

- A comprehensive history;
- A comprehensive examination; and
- Medical decision making of moderate to high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The creation of a medical plan of care is required.

Physicians typically spend 50 minutes at the bedside and on the patient's facility floor or unit.

Subsequent Nursing Facility Care *New or Established Patients*

The following codes are used to report the services provided to residents of nursing facilities who do not require a comprehensive assessment, and/or who have not had a major, permanent change of status.

All levels include reviewing the medical record, noting changes in the resident's status since the last visit, and reviewing and signing orders.

99311 Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components:

- A problem focused interval history;
- A problem focused examination; and

and

- Medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit.

99312 Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components:

- An expanded problem focused interval history;
- An expanded problem focused examination; and
- Medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is responding inadequately to therapy or has developed a minor complication.

Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.

99313 Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components:

- A detailed interval history;
- A detailed examination; and
- Medical decision making of moderate to high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient has developed a significant complication or a significant new problem.

Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.

Domiciliary, Rest Home (e.g., Boarding Home), Or Custodial Care Services

The following codes are used to report evaluation/management services in a facility which provides room, board and other personal assistance services, generally on a long-term basis. The facility's services do not include a medical component.

For definitions of key components and commonly used terms, please see Evaluation and Management Services Guidelines.

Typical times have not been established for this category of services.

New Patient

99321 Domiciliary or rest home visit for the evaluation and management of a new patient which requires these three key components:

- A problem focused history;
- A problem focused examination; and
- Medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low severity.

93222 Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components:

- An expanded problem focused history;
- An expanded problem focused examination; and
- Medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate severity.

99323 Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components:

- A detailed history;
- A detailed examination; and
- Medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of high complexity.

Established Patient

99331 Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- A problem focused interval history;
- A problem focused examination;
- Medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving.

99332 Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- An expanded problem focused interval history;
- An expanded problem focused examination; and
- Medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature

of the problem(s) and the patient's and/or family's needs.

Usually, the patient is responding inadequately to therapy or has developed a minor complication.

99333 Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- A detailed interval history;
- A detailed examination;
- Medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is unstable or has developed a significant complication or a significant new problem.

Home Services

The following codes are used to report evaluation/management services provided in a private residence.

For definitions of key components and commonly used terms, please see Evaluation and Management Services Guidelines.

Typical times have not been established for this category of services.

New Patient

99341 Home visit for the evaluation and management of a new patient, which requires these three key components:

- A problem focused history;
- A problem focused examination; and
- Medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low severity.

99342 Home visit for the evaluation and management of a new patient, which requires these three key components:

- An expanded problem focused history;
- An expanded problem focused examination;
- Medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate severity.

99343 Home visit for the evaluation and management of a new patient, which requires these three key components:

- A detailed history;
- A detailed examination;
- Medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of high severity.

Established Patient

99351 Home visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- A problem focused interval history;
- A problem focused examination; and
- Medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving.

99352 Home visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- An expanded problem focused interval history;
- An expanded problem focused examination; and
- Medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is responding inadequately to therapy or has developed a minor complication.

99353 Home visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- A detailed interval history;
- A detailed examination;
- Medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is unstable or has developed a significant complication or a significant new problem.

Case Management Services

Physician case management is a process in which a physician is responsible for direct care of a patient, and for coordinating and controlling access to or initiating and/or supervising other health care services needed by the patient.

Team Conferences

99361 Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 30 minutes.

99362 approximately 60 minutes.

Telephone Calls

99371 Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (e.g., nurses, therapists, social workers, nutritionists, physicians, pharmacists); simple or brief (e.g., to report on tests and/or laboratory results, to clarify or alter previous instructions, to integrate new information from other health professionals into the medical treatment plan, or to adjust therapy).

99372 Intermediate (e.g., to provide advice to an established patient on a new problem, to initiate therapy that can be handled by telephone, to discuss test results in detail, to coordinate medical management of a new problem in an established patient, to discuss and evaluate new information and details, or to initiate new plan of care).

99373 Complex or lengthy (e.g., lengthy counseling session with anxious or distraught patient, detailed or prolonged discussion with family members regarding seriously ill patient, lengthy communication necessary to coordinate complex services of several different health professionals working on different aspects of the total patient care plan).

Preventive Medicine Services

The following codes are used to report the routine evaluation and management of adults and children when these services are performed in the absence of patient complaints. The extent and focus of the services will largely depend on the age of the patient, the circumstances of the examination, and the abnormalities encountered.

Codes 99381-99387 do not include counseling, risk factor reduction interventions or immunizations. For counseling and/or risk factor reduction interventions, see 99401-99412. For immunizations, see 90741-90749. Ancillary studies involving laboratory,

radiology, or other procedures are reported separately.

New Patient

99381 Initial evaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures, new patient; infant (age under 1 year).

99382 Early childhood (age 1 through 4 years).

99383 Late childhood (age 5 through 11 years).

99384 Adolescent (age 12 through 17 years).

99385 18-39 years.

99386 40-64 years.

99387 65 years and over.

Established Patient

99391 Periodic reevaluation and management of a healthy individual requiring a comprehensive history, comprehensive examination, the identification of risk factors and the ordering of appropriate laboratory/diagnostic procedures, established patient; infant (age under 1 year).

99392 Early childhood (age 1 through 4 years).

99393 Late childhood (age 5 through 11 years).

99394 Adolescent (age 12 through 17 years).

99395 18-39 years.

99396 40-64 years.

99397 65 years and over.

Counseling and/or Risk Factor Reduction Intervention

New or Established Patient

These codes are used to report services provided to healthy individuals for the purpose of promoting health and preventing illness or injury. Counseling and risk factor reduction interventions provided in conjunction with an initial or periodic preventive medicine visit will vary with age and should address such issues as family problems, diet and exercise, substance abuse, sexual practices, injury prevention and dental health.

These codes are not to be used to report counseling and risk factor reduction interventions provided to patients with symptoms or established illness. For counseling individual patients with symptoms or established illnesses, use the appropriate office, hospital or consultation or other evaluation/management codes. For counseling groups of patients with symptoms or established illnesses, use 99078.

Preventive Medicine, Individual Counseling

99401 Counseling and/or risk factor reduction intervention(s) provided to a healthy individual; approximately 15 minutes.

99402 Approximately 30 minutes.

99403 Approximately 45 minutes.

99404 Approximately 60 minutes.

Preventive Medicine, Group Counseling

99411 Counseling and/or risk factor reduction intervention(s) provided to healthy individuals in a group setting; approximately 30 minutes.

99412 Approximately 60 minutes.

Other Preventive Medicine Services

99420 Administration and interpretation of health risk assessment

instrument (e.g., health hazard appraisal).

99429 Unlisted preventive medicine service.

Newborn Care

The following codes are used to report the services provided to normal or high risk newborns in several different settings. For hospital discharge services, use 99238.

99431 History and examination of the normal newborn infant, initiation of diagnostic and treatment programs and preparation of hospital records. (This code should also be used for birthing room deliveries.)

99432 Normal newborn care in other than hospital or birthing room setting, including physical examination of baby

and conference(s) with parent(s).

99433 Subsequent hospital care, for the evaluation and management of a normal newborn, per day.

99438 Infant care to one year of age, with a maximum of 12 office visits during regular office hours, including tuberculin skin testing and administration of DTP and oral polio vaccine.

99440 Newborn resuscitation: care of the high risk newborn at delivery, including, for example, inhalation therapy, aspiration, administration of medication for initial stabilization.

Other Evaluation and Management Services

99499 Unlisted evaluation and management service.

BILLING CODE 4120-03-M

ADDENDUM F
PROCEDURE CODES SUBJECT TO THE OUTPATIENT LIMIT

HCP*CS*	DESCRIPTION
10040	ACNE SURGERY
10060	DRAINAGE OF SKIN ABSCESS
10061	DRAINAGE OF SKIN ABSCESS
10080	DRAINAGE OF PILONIDAL CYST
10120	REMOVE FOREIGN BODY
10121	REMOVE FOREIGN BODY
10140	DRAINAGE OF HEMATOMA
10141	DRAINAGE OF HEMATOMA
10160	PUNCTURE DRAINAGE OF LESION
11000	SURGICAL CLEANSING OF SKIN
11001	ADDITIONAL CLEANSING OF SKIN
11040	SURGICAL CLEANSING, ABRASION
11041	SURGICAL CLEANSING OF SKIN
11042	CLEANSING OF SKIN/TISSUE
11050	TRIM SKIN LESION
11051	TRIM 2 TO 4 SKIN LESIONS
11052	TRIM OVER 4 SKIN LESIONS
11100	BIOPSY OF LESION
11101	BIOPSY, EACH ADDITIONAL LESION
11200	REMOVAL OF SKIN TAGS
11201	REMOVAL OF ADDED SKIN TAGS
11400	REMOVAL OF SKIN LESION
11401	REMOVAL OF SKIN LESION
11402	REMOVAL OF SKIN LESION
11403	REMOVAL OF SKIN LESION
11404	REMOVAL OF SKIN LESION
11420	REMOVAL OF SKIN LESION
11421	REMOVAL OF SKIN LESION
11422	REMOVAL OF SKIN LESION
11423	REMOVAL OF SKIN LESION
11424	REMOVAL OF SKIN LESION
11440	REMOVAL OF SKIN LESION
11441	REMOVAL OF SKIN LESION
11442	REMOVAL OF SKIN LESION
11443	REMOVAL OF SKIN LESION
11444	REMOVAL OF SKIN LESION
11446	REMOVAL OF SKIN LESION
11600	REMOVAL OF SKIN LESION
11601	REMOVAL OF SKIN LESION
11602	REMOVAL OF SKIN LESION
11603	REMOVAL OF SKIN LESION
11604	REMOVAL OF SKIN LESION
11620	REMOVAL OF SKIN LESION
11621	REMOVAL OF SKIN LESION
11622	REMOVAL OF SKIN LESION
11623	REMOVAL OF SKIN LESION
11624	REMOVAL OF SKIN LESION

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ADDENDUM F
PROCEDURE CODES SUBJECT TO THE OUTPATIENT LIMIT

HCP*CS*	DESCRIPTION
11640	REMOVAL OF SKIN LESION
11641	REMOVAL OF SKIN LESION
11642	REMOVAL OF SKIN LESION
11643	REMOVAL OF SKIN LESION
11644	REMOVAL OF SKIN LESION
11700	SURGICAL CLEANSING OF NAILS
11701	SURGICAL CLEANSING OF NAILS
11710	SURGICAL CLEANSING OF NAILS
11711	SURGICAL CLEANSING OF NAILS
11730	REMOVAL OF NAIL PLATE
11731	REMOVAL OF SECOND NAIL PLATE
11732	REMOVE NAIL PLATE, ADDITIONAL
11740	DRAIN BLOOD FROM UNDER NAIL
11750	REMOVAL OF NAIL BED
11760	RECONSTRUCTION OF NAIL BED
11762	RECONSTRUCTION OF NAIL BED
11765	EXCISION OF NAIL FOLD, TOE
11900	INJECTION INTO SKIN LESIONS
11901	SKIN LESION INJECTIONS, ADDITIONAL
13100	REPAIR OF WOUND OR LESION
13101	REPAIR OF WOUND OR LESION
13131	REPAIR OF WOUND OR LESION
13132	REPAIR OF WOUND OR LESION
13150	REPAIR OF WOUND OR LESION
14000	SKIN TISSUE REARRANGEMENT
14020	SKIN TISSUE REARRANGEMENT
14040	SKIN TISSUE REARRANGEMENT
15851	REMOVAL OF SUTURES
16000	INITIAL TREATMENT OF BURN(S)
16010	TREATMENT OF BURN(S)
16020	TREATMENT OF BURN(S)
16025	TREATMENT OF BURN(S)
17000	DESTRUCTION OF FACE LESION
17001	DESTRUCTION OF ADDED LESIONS
17002	DESTRUCTION OF ADDED LESIONS
17010	DESTRUCTION SKIN LESION(S)
17100	DESTRUCTION OF SKIN LESION
17101	DESTRUCTION OF 2ND LESION
17102	DESTRUCTION OF ADDED LESIONS
17104	DESTRUCTION OF SKIN LESIONS
17105	DESTRUCTION OF SKIN LESIONS
17110	DESTRUCTION OF SKIN LESIONS
17200	ELECTROCAUTERY OF SKIN TAGS
17201	ELECTROCAUTERY ADDED LESIONS
17250	CHEMICAL CAUTERY OF WOUND
17304	CHEMOSURGERY OF SKIN LESION
17305	2ND STAGE CHEMOSURGERY

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ADDENDUM F
PROCEDURE CODES SUBJECT TO THE OUTPATIENT LIMIT

HCP*CS*	DESCRIPTION
17306	3RD STAGE CHEMOSURGERY
17307	FOLLOWUP SKIN LESION THERAPY
17310	EXTENSIVE SKIN CHEMOSURGERY
17340	CRYOTHERAPY OF SKIN
17360	SKIN PEEL THERAPY
19000	DRAINAGE OF BREAST LESION
19100	BIOPSY OF BREAST
20000	INCISION OF ABSCESS
20500	INJECTION OF SINUS TRACT
20520	REMOVAL OF FOREIGN BODY
20550	INJECTION TREATMENT
20600	DRAINAGE JOINT/BURSA/CYST
20605	DRAINAGE JOINT/BURSA/CYST
20610	INJECT/DRAIN JOINT/BURSA
20615	TREATMENT OF BONE CYST
20670	REMOVAL OF SUPPORT IMPLANT
21030	REMOVAL OF FACE BONE LESION
21040	REMOVAL OF JAW BONE LESION
23066	BIOPSY SHOULDER TISSUES
24650	TREAT RADIUS FRACTURE
25500	TREAT FRACTURE OF RADIUS
25600	TREAT FRACTURE RADIUS/ULNA
26010	DRAINAGE OF FINGER ABSCESS
26600	TREAT METACARPAL FRACTURE
26605	TREAT METACARPAL FRACTURE
26720	TREAT FINGER FRACTURE, EACH
27520	TREAT KNEECAP FRACTURE
27780	TREATMENT OF FIBULA FRACTURE
27786	TREATMENT OF ANKLE FRACTURE
28001	DRAINAGE OF BURSA OF FOOT
28010	INCISION OF TOE TENDON
28090	REMOVAL OF FOOT LESION
28108	REMOVAL OF TOE LESIONS
28124	PARTIAL REMOVAL OF TOE
28126	PARTIAL REMOVAL OF TOE
28153	PARTIAL REMOVAL OF TOE
28160	PARTIAL REMOVAL OF TOE
28190	REMOVAL OF FOOT FOREIGN BODY
28230	INCISION OF FOOT TENDON(S)
28232	INCISION OF TOE TENDON
28234	INCISION OF FOOT TENDON
28270	RELEASE OF FOOT CONTRACTURE
28272	RELEASE OF TOE JOINT, EACH
28285	REVISION OF HAMMERTOE
28298	CORRECTION OF BUNION
28308	INCISION OF METATARSAL
28400	TREATMENT OF HEEL FRACTURE

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ADDENDUM F
PROCEDURE CODES SUBJECT TO THE OUTPATIENT LIMIT

HCP*CS*	DESCRIPTION
28470	TREAT METATARSAL FRACTURE
28475	TREAT METATARSAL FRACTURE
28490	TREAT BIG TOE FRACTURE
28510	TREATMENT OF TOE FRACTURE
28515	TREATMENT OF TOE FRACTURE
29065	APPLICATION OF LONG ARM CAST
29075	APPLICATION OF FOREARM CAST
29085	APPLY HAND/WRIST CAST
29105	APPLY LONG ARM SPLINT
29125	APPLY FOREARM SPLINT
29126	APPLY FOREARM SPLINT
29130	APPLICATION OF FINGER SPLINT
29200	STRAPPING OF CHEST
29260	STRAPPING OF ELBOW OR WRIST
29345	APPLICATION OF LONG LEG CAST
29355	APPLICATION OF LONG LEG CAST
29365	APPLICATION OF LONG LEG CAST
29405	APPLY SHORT LEG CAST
29425	APPLY SHORT LEG CAST
29435	APPLY SHORT LEG CAST
29440	ADDITION OF WALKER TO CAST
29515	APPLICATION LOWER LEG SPLINT
29520	STRAPPING OF HIP
29530	STRAPPING OF KNEE
29540	STRAPPING OF ANKLE
29550	STRAPPING OF TOES
29580	APPLICATION OF PASTE BOOT
29700	REMOVAL/REVISION OF CAST
29705	REMOVAL/REVISION OF CAST
30100	INTRANASAL BIOPSY
30110	REMOVAL OF NOSE POLYP(S)
30200	INJECTION TREATMENT OF NOSE
30210	NASAL SINUS THERAPY
30901	CONTROL OF NOSEBLEED
31000	IRRIGATION MAXILLARY SINUS
31250	NASAL ENDOSCOPY, DIAGNOSTIC
31505	DIAGNOSTIC LARYNGOSCOPY
31525	DIAGNOSTIC LARYNGOSCOPY
31575	FIBERSCOPIC LARYNGOSCOPY
36400	ESTABLISH ACCESS TO VEIN
36425	ESTABLISH ACCESS TO VEIN
36470	INJECTION THERAPY OF VEIN
36471	INJECTION THERAPY OF VEINS
36500	INSERTION OF CATHETER, VEIN
38505	NEEDLE BIOPSY,LYMPH NODE(S)
40490	BIOPSY OF LIP
40808	BIOPSY OF MOUTH LESION

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ADDENDUM F
PROCEDURE CODES SUBJECT TO THE OUTPATIENT LIMIT

HCPCS*	DESCRIPTION
40810	EXCISION OF MOUTH LESION
40812	EXCISE/REPAIR MOUTH LESION
41100	BIOPSY OF TONGUE
41108	BIOPSY OF FLOOR OF MOUTH
41112	EXCISION OF TONGUE LESION
42100	BIOPSY ROOF OF MOUTH
42330	REMOVAL OF SALIVARY STONE
42650	DILATION OF SALIVARY DUCT
42800	BIOPSY OF THROAT
45300	PROCTOSIGMOIDOSCOPY
45302	PROCTOSIGMOIDOSCOPY
45303	PROCTOSIGMOIDOSCOPY
45305	PROCTOSIGMOIDOSCOPY; BIOPSY
45310	PROCTOSIGMOIDOSCOPY
45330	SIGMOIDOSCOPY
45355	SURGICAL COLONOSCOPY
46050	INCISION OF ANAL ABSCESS
46083	INCISE EXTERNAL HEMORRHOID
46221	LIGATION OF HEMORRHOID(S)
46230	REMOVAL OF ANAL TABS
46320	REMOVAL OF HEMORRHOID CLOT
46500	INJECTION INTO HEMORRHOIDS
46600	DIAGNOSTIC ANOSCOPY
46602	DIAGNOSTIC ANOSCOPY
46604	ANOSCOPY AND DILATION
46614	ANOSCOPY; CONTROL BLEEDING
46900	DESTRUCTION, ANAL LESION(S)
46934	DESTRUCTION OF HEMORRHOIDS
46936	DESTRUCTION OF HEMORRHOIDS
46945	LIGATION OF HEMORRHOIDS
50690	INJECTION FOR URETER X-RAY
51700	IRRIGATION OF BLADDER
51705	CHANGE OF BLADDER TUBE
51720	TREATMENT OF BLADDER LESION
52000	CYSTOSCOPY
52281	CYSTOSCOPY AND TREATMENT
53600	DILATE URETHRA STRICTURE
53601	DILATE URETHRA STRICTURE
53620	DILATE URETHRA STRICTURE
53621	DILATE URETHRA STRICTURE
53660	DILATION OF URETHRA
53661	DILATION OF URETHRA
53670	INSERT URINARY CATHETER
54235	PENILE INJECTION
55000	DRAINAGE OF HYDROCELE
55700	BIOPSY OF PROSTATE
56501	DESTRUCTION, VULVA LESION(S)

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ADDENDUM F
PROCEDURE CODES SUBJECT TO THE OUTPATIENT LIMIT

HCP*CS*	DESCRIPTION
56600	BIOPSY OF VULVA
57100	BIOPSY OF VAGINA
57150	TREAT VAGINA INFECTION
57160	INSERTION OF PESSARY
57452	EXAMINATION OF VAGINA
57454	VAGINA EXAMINATION & BIOPSY
57500	BIOPSY OF CERVIX
57505	ENDOCERVICAL CURETTAGE
57510	CAUTERIZATION OF CERVIX
57511	CRYOCAUTERY OF CERVIX
58100	BIOPSY OF UTERUS LINING
58102	CURETTAGE OF UTERUS LINING
59420	CARE BEFORE DELIVERY
60100	BIOPSY OF THYROID
61070	BRAIN CANAL SHUNT PROCEDURE
64400	INJECTION FOR NERVE BLOCK
64405	INJECTION FOR NERVE BLOCK
64413	INJECTION FOR NERVE BLOCK
64415	INJECTION FOR NERVE BLOCK
64418	INJECTION FOR NERVE BLOCK
64420	INJECTION FOR NERVE BLOCK
64425	INJECTION FOR NERVE BLOCK
64440	INJECTION FOR NERVE BLOCK
64441	INJECTION FOR NERVE BLOCK
64445	INJECTION FOR NERVE BLOCK
64450	INJECTION FOR NERVE BLOCK
64505	INJECTION FOR NERVE BLOCK
64550	APPLY NEUROSTIMULATOR
64565	IMPLANT NEUROELECTRODES
64640	INJECTION TREATMENT OF NERVE
65205	REMOVE FOREIGN BODY FROM EYE
65210	REMOVE FOREIGN BODY FROM EYE
65220	REMOVE FOREIGN BODY FROM EYE
65222	REMOVE FOREIGN BODY FROM EYE
65430	CORNEAL SMEAR
65435	CURETTE/TREAT CORNEA
66761	REVISION OF IRIS
66762	REVISION OF IRIS
67031	LASER SURGERY, EYE STRANDS
67105	REPAIR, DETACHED RETINA
67141	TREATMENT OF RETINA
67145	TREATMENT OF RETINA
67208	TREATMENT OF RETINAL LESION
67210	TREATMENT OF RETINAL LESION
67228	TREATMENT OF RETINAL LESION
67505	INJECT/TREAT EYE SOCKET
67515	INJECT/TREAT EYE SOCKET

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ADDENDUM F
PROCEDURE CODES SUBJECT TO THE OUTPATIENT LIMIT

HCPs*	DESCRIPTION
67700	DRAINAGE OF EYELID ABSCESS
67800	REMOVE EYELID LESION
67801	REMOVE EYELID LESIONS
67810	BIOPSY OF EYELID
67820	REVISE EYELASHES
67825	REVISE EYELASHES
67840	REMOVE EYELID LESION
67850	TREAT EYELID LESION
67921	REPAIR EYELID DEFECT
68020	INCISE/DRAIN EYELID LINING
68110	REMOVE EYELID LINING LESION
68200	TREAT EYELID BY INJECTION
68440	INCISE TEAR DUCT OPENING
68700	REPAIR TEAR DUCTS
68760	CLOSE TEAR DUCT OPENING
68800	DILATE TEAR DUCT OPENING(S)
68820	EXPLORE TEAR DUCT SYSTEM
68830	REOPEN TEAR DUCT CHANNEL
68840	EXPLORE/IRRIGATE TEAR DUCTS
69000	DRAIN EXTERNAL EAR LESION
69020	DRAIN OUTER EAR CANAL LESION
69100	BIOPSY OF EXTERNAL EAR
69200	CLEAR OUTER EAR CANAL
69210	REMOVE IMPACTED EAR WAX
69220	CLEAN OUT MASTOID CAVITY
69222	CLEAN OUT MASTOID CAVITY
69400	INFLATE MIDDLE EAR CANAL
69401	INFLATE MIDDLE EAR CANAL
69420	INCISION OF EARDRUM
69433	CREATE EARDRUM OPENING
69610	REPAIR OF EARDRUM
92002	EYE EXAM & TREATMENT, NEW
92004	EYE EXAM & TREATMENT, NEW
92012	EYE EXAM & TREATMENT, ESTABLISHED
92014	EYE EXAM & TREATMENT, ESTABLISHED
92018	EYE EXAM & TREATMENT, NEW
92020	SPECIAL EYE EVALUATION
92060	SPECIAL EYE EVALUATION
92065	ORTHOPTIC/PLEOPTIC TRAINING
92070	FITTING OF CONTACT LENS
92081	VISUAL FIELD EXAMINATION(S)
92082	VISUAL FIELD EXAMINATION(S)
92083	VISUAL FIELD EXAMINATION(S)
92100	SERIAL TONOMETRY EXAM(S)
92120	TONOGRAPHY & EYE EVALUATION
92130	WATER PROVOCATION TONOGRAPHY
92140	GLAUCOMA PROVOCATIVE TESTS

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ADDENDUM F
PROCEDURE CODES SUBJECT TO THE OUTPATIENT LIMIT

HCPCS*	DESCRIPTION
92225	EXTENDED OPHTHALMOSCOPY, NEW
92226	EXTENDED OPHTHALMOSCOPY
92230	OPHTHALMOSCOPY/ANGIOSCOPY
92235	OPHTHALMOSCOPY/ANGIOGRAPHY
92270	ELECTRO-OCULOGRAPHY
92275	ELECTRORETINOGRAPHY
92280	SPECIAL EYE EVALUATION
92283	COLOR VISION EXAMINATION
92284	DARK ADAPTATION EYE EXAM
92286	INTERNAL EYE PHOTOGRAPHY
92311	SPECIAL CONTACT LENS FITTING
92312	SPECIAL CONTACT LENS FITTING
92352	SPECIAL SPECTACLES FITTING
92353	SPECIAL SPECTACLES FITTING
92504	EAR MICROSCOPY EXAMINATION
92506	SPEECH & HEARING EVALUATION
92507	SPEECH/HEARING THERAPY
92511	NASOPHARYNGOSCOPY
92516	FACIAL NERVE FUNCTION TEST
93797	CARDIAC REHAB
93798	CARDIAC REHAB/MONITOR
95831	LIMB MUSCLE TESTING, MANUAL
95832	HAND MUSCLE TESTING, MANUAL
95833	BODY MUSCLE TESTING, MANUAL
95834	BODY MUSCLE TESTING, MANUAL
95851	RANGE OF MOTION MEASUREMENTS
95852	RANGE OF MOTION MEASUREMENTS
95857	TENSILON TEST
96440	CHEMOTHERAPY, INTRACAVITARY
99201	OFFICE AND OTHER OUTPATIENT, NEW PATIENT, LEVEL 1
99202	OFFICE AND OTHER OUTPATIENT, NEW PATIENT, LEVEL 2
99203	OFFICE AND OTHER OUTPATIENT, NEW PATIENT, LEVEL 3
99204	OFFICE AND OTHER OUTPATIENT, NEW PATIENT, LEVEL 4
99205	OFFICE AND OTHER OUTPATIENT, NEW PATIENT, LEVEL 5
99211	OFFICE AND OTHER OUTPATIENT, ESTABLISHED PATIENT, LEVEL 1
99212	OFFICE AND OTHER OUTPATIENT, ESTABLISHED PATIENT, LEVEL 1
99213	OFFICE AND OTHER OUTPATIENT, ESTABLISHED PATIENT, LEVEL 1
99214	OFFICE AND OTHER OUTPATIENT, ESTABLISHED PATIENT, LEVEL 1
99215	OFFICE AND OTHER OUTPATIENT, ESTABLISHED PATIENT, LEVEL 1
A2000	MANIPULATION OF SPINE BY CHIROPRACTOR
H5300	OCCUPATIONAL THERAPY
M0005	OFFICE VISITS WITH TWO OR MORE MODALITIES TO THE SAME AREA
M0006	OFFICE VISITS WITH ONE OF THE ABOVE MENTIONED TREATMENT
M0007	OFFICE VISIT INCLUDING COMBINATION OF ANY MODALITY(S) AND
M0008	OFFICE VISIT INCLUDING COMBINATION OF ANY MODALITY(S) AND
M0101	CUTTING OR REMOVAL OF CORNS, CALLUSES AND/OR TRIMMING OF NAILS, APPLICATION
M0702	BRIEF, OSTEOPATHIC MANIPULATIVE THERAPY PERFORMED IN OFFICE, OR

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ADDENDUM F
PROCEDURE CODES SUBJECT TO THE OUTPATIENT LIMIT

HCPCS*	DESCRIPTION
M0704	LIMITED, OSTEOPATHIC MANIPULATIVE THERAPY PERFORMED
M0706	INTERMEDIATE OSTEOPATHIC MANIPULATIVE THERAPY PERFORMED
M0708	EXTENDED OSTEOPATHIC MANIPULATIVE THERAPY PERFORMED
M0710	COMPREHENSIVE OSTEOPATHIC MANIPULATIVE THERAPY PERFORMED

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ADDENDUM G
Facility-Based Procedures for which Additional
Amount for Supplies May be Payable
If Performed in a Physician's Office

HCP*CS*	DESCRIPTION
19101	BIOPSY OF BREAST
19120	REMOVAL OF BREAST LESION
20200	MUSCLE BIOPSY
20205	DEEP MUSCLE BIOPSY
20220	BONE BIOPSY, TROCAR/NEEDLE
20225	BONE BIOPSY, TROCAR/NEEDLE
20240	BONE BIOPSY, EXCISIONAL
25111	REMOVE WRIST TENDON LESION
28290	CORRECTION OF BUNION
28292	CORRECTION OF BUNION
28293	CORRECTION OF BUNION
28294	CORRECTION OF BUNION
28296	CORRECTION OF BUNION
28297	CORRECTION OF BUNION
28298	CORRECTION OF BUNION
28299	CORRECTION OF BUNION
32000	DRAINAGE OF CHEST
37609	TEMPORAL ARTERY PROCEDURE
38500	BIOPSY/REMOVAL, LYMPH NODE(S)
43200	ESOPHAGUS ENDOSCOPY
43202	ESOPHAGUS ENDOSCOPY, BIOPSY
43220	ESOPHAGUS ENDOSCOPY, DILATION
43226	ESOPHAGUS ENDOSCOPY, DILATION
43234	UPPER GI ENDOSCOPY, EXAM
43235	UPPER GI ENDOSCOPY, DIAGNOSIS
43239	UPPER GI ENDOSCOPY, BIOPSY
43245	OPERATIVE UPPER GI ENDOSCOPY
43247	OPERATIVE UPPER GI ENDOSCOPY
43251	OPERATIVE UPPER GI ENDOSCOPY
45378	DIAGNOSTIC COLONOSCOPY
45379	COLONOSCOPY
45380	COLONOSCOPY AND BIOPSY
45382	COLONOSCOPY, CONTROL BLEEDING
45383	COLONOSCOPY, LESION REMOVAL
45385	COLONOSCOPY, LESION REMOVAL
49080	PUNCTURE, PERITONEAL CAVITY
57520	BIOPSY OF CERVIX
58120	DILATION AND CURETTAGE
62270	SPINAL FLUID TAP, DIAGNOSTIC
85095	BONE MARROW ASPIRATION
85102	BONE MARROW BIOPSY
96440	CHEMOTHERAPY, INTRACAVITARY
96445	CHEMOTHERAPY, INTRACAVITARY
96450	CHEMOTHERAPY, INTO CNS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

RIN 0938-AF24

[BPD-703-N]

Physician Fee Schedule Update for Calendar Year 1992 and Physician Performance Standard Rates of Increase for Federal Fiscal Year 1992

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Notice.

SUMMARY: This notice announces the calendar year 1992 update to the Medicare physician fee schedule and the Federal fiscal year 1992 performance standard rates of increase for expenditures and volume of physician services under the Medicare Supplementary Medical Insurance (Part B) program as required by sections 1848 (d) and (f) respectively of the Social Security Act. The fee schedule update for calendar year 1992 is 1.9 percent. The physician performance standard rates of increase for Federal fiscal year 1992 are 10.0 percent for all physician services, 6.5 percent for surgical services, and 11.2 percent for nonsurgical services.

EFFECTIVE DATE: The performance standard rates of increase are effective on October 1, 1991. The Medicare physician fee schedule update is effective on January 1, 1992.

FOR FURTHER INFORMATION CONTACT: Terrence L. Kay (301) 966-4494.

SUPPLEMENTARY INFORMATION:

I. Background and Summary of Legislation

A. Physician Payment Reform

On December 19, 1989, the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101-239) was enacted. Section 6102 of Public Law 101-239 amended Title XVIII of the Social Security Act (the Act) by adding a new section 1848, Payment For Physicians' Services. New section 1848 of the Act provides for a comprehensive package of Medicare physician payment reform, effective for services furnished on or after January 1, 1992, that includes the following provisions:

- The current reasonable charge payment mechanism, which uses actual, customary, and prevailing charges, is being replaced by a resource-based fee schedule.
- Performance standard rates of increase are established to control the rate of growth in expenditures for physician services.

• Medicare beneficiaries are protected from liability for charges for physician services that exceed a specific percentage of the Medicare payment amount.

On June 5, 1991, at 56 FR 25792, we published a proposed rule to implement most of the provisions of section 1848 of the Act concerning the physician fee schedule. Under section 1848(b)(1) of the Act, payment for a physician's service will equal the product of the relative value units for a service, a geographic adjustment factor, and a conversion factor. Relative value units measure the relative amount of resources used by physicians to provide different services and the geographic adjustment factor measures practice cost differences between areas. As provided in section 1848(d)(1)(B) of the Act, the initial or base conversion factor is computed to produce total payments under the physician fee schedule as if it had been in effect in CY 1991 that equal our estimate of total payments in CY 1991 under the current payment system for physicians. The base conversion factor will be published in the final rule implementing the physician fee schedule because it cannot be determined before the fee schedule is completed.

Under section 1848(d)(2) of the Act, the Secretary recommends a fee schedule update to Congress by April 15. Under section 1848(d)(2)(F) of the Act, the Physician Payment Review Commission reviews the recommendation and makes its own recommendation by May 15. If Congress does not set an update, the update will be established through a formula as set forth in subsection 1848(d)(3) of the Act. Under this formula, the update will equal the percentage increase in the MEI increased or decreased by the percentage that the increase in actual expenditures in the second preceding fiscal year (FY) over the third preceding fiscal year exceeded or was less than the performance standard rates of increase for the second preceding fiscal year. The downward adjustment in the update is limited to 2.0 percentage points in 1992 and 1993, 2.5 percentage points in 1994 and 1995, and 3.0 percentage points in any succeeding year. There is no restriction on upward adjustments to the update.

Section 1848(f) of the Act requires the Secretary to establish performance standard rates of increase for expenditures and volume of physician services. Congress enacted this provision to address the problem of unacceptably high annual rates of increase in Medicare expenditures for physician services. Past efforts, such as freezing physician fees (which was in

effect from 1984 to 1986), have achieved only limited success in slowing the rate of increase because both the volume and intensity of physician services have increased. The use of performance standard rates of increase is intended to involve physicians in the effort to slow the unacceptably high annual rate of increase in expenditures by having physicians carefully evaluating their services and eliminating those that are inappropriate or ineffective.

Under section 1848(f)(1) of the Act, the Secretary recommends performance standard rates of increase by April 15 of each year for all physician services, and for the categories of surgical and nonsurgical services. (We defined surgical services in a *Federal Register* notice on May 3, 1990 (55 FR 18868).) Congress then establishes physician performance standard rates of increase, or, if Congress does not act after the Secretary's recommendation, the performance standard rates of increase are determined through use of the formula provided in sections 1848(f)(2) (A) and (B) of the Act. The physician performance standard rate of increase for FY 1990, computed as specified by section 1848(f)(1)(D) of the Act, was 9.1 percent. Sections 1848(f)(1) (C) and (D) of the Act did not require separate standards for each category of physician services for FY 1990. The FY 1990 performance standard rate of increase was published in the *Federal Register* on December 29, 1989 (54 FR 53838).

For FY 1991, the performance standard rates of increase were determined in accordance with the formula provided in section 1848(f)(2)(C) of the Act, which was added by section 4105(c)(2) of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101-508), enacted November 5, 1990. Section 1848(f)(2)(C) of the Act requires the Secretary to define surgical services and nonsurgical services separately, and to determine a performance standard increase for each category beginning with FY 1991. The performance standard rates of increase for FY 1991 were the following: 7.3 percent for all physician services, 3.3 percent for surgical services, and 8.6 percent for nonsurgical services. The FY 1991 performance standard rates of increase were published in the *Federal Register* on December 28, 1990 (55 FR 53356).

The performance standard rates of increase are not limits on expenditures. Payments for services will not be withheld if performance standard rates of increase are exceeded. Rather, as discussed above, the appropriate fee schedule update, as specified in section 1848(d)(3)(A) of the Act, is adjusted to

reflect the success or failure in meeting the performance standard rates of increase.

B. Determining the Physician Fee Schedule Update

Section 1848(d) of the Act sets forth the process for establishing the physician fee schedule update. As explained above, section 1848(d)(2) of the Act requires that, by April 15 of each year (beginning in 1991), the Secretary shall provide Congress with his or her recommendation of a physician fee schedule update. Under section 1848(d)(2)(A) of the Act the Secretary is required to consider the following factors:

- The percentage change in the MEI, a measure of the increase in the cost of operating a medical practice.
- The percentage by which actual expenditures for all physicians' services in the first preceding fiscal year were less than or exceeded the actual expenditures in the second preceding fiscal year.
- The relationship between the percentage determined above for a fiscal year and the performance standard rate of increase for that fiscal year. This factor is to be adjusted to account for changes in the proportion of Medicare beneficiaries enrolling in health maintenance organizations (HMOs).
- Changes in the volume and intensity of services.
- Access to services.
- Other factors that may contribute to changes in volume and intensity of services or access to services.

Under section 1848(d)(2)(B) of the Act the Secretary also may consider the following factors in making his or her recommendation to Congress:

- Unexpected changes by physicians in response to implementation of the fee schedule.
- Unexpected changes in outlay projections.
- Changes in the quality or appropriateness of care.
- Any other relevant factors not measured in the resource-based payment methodology.

The Secretary recommended a physician fee schedule update for CY 1992 of 2.2 percent. This recommendation was based on our April estimate of the update using the methodology specified in section 1848(d)(3) of the Act which is to be used if Congress does not set the update. As required by section 1848(d)(2)(F) of the Act, the Physician Payment Review Commission reviewed our recommendation and also recommended a 2.2 percent update for CY 1992.

If Congress does not set the update, section 1848(d)(3) of the Act establishes the process for updating the physician fee schedule. Section 1848(d)(1)(C) of the Act requires the Secretary to publish in the *Federal Register* in the last 15 days of October the update for the following calendar year. For example, the Secretary is required to publish the CY 1992 update by October 31, 1991.

Under section 1848(d)(3) of the Act, unless otherwise specified by Congress, the fee schedule update equals the appropriate update index (that is, the MEI) adjusted by the percentage by which expenditures exceeded or were less than the performance standard rates of increase for the second preceding year. However, section 1848(d)(3)(A)(iii) of the Act as added by section 4105(a)(3)(B) of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101-508) provides that, for services furnished in CY 1992 for which the appropriate update index is the MEI, the fee schedule update is equal to the MEI update reduced by 0.4 percentage points. Since Congress has not set the update, we are publishing the CY 1992 physician fee schedule update using the methodology specified in section 1848(d)(3) of the Act. We will announce the base year and the updated conversion factor in the final rule that implements the physician fee schedule.

C. Determining the Performance Standard Rates of Increase

Section 1848(f)(1) of the Act sets forth the process for establishing the performance standard rates of increase. As explained above, section 1848(f)(1)(A) of the Act requires that the Secretary recommend to Congress the physician performance standard rates of increase for the following Federal fiscal year by not later than April 15, beginning with CY 1990. In making the recommendations, the Secretary is required to confer with organizations that represent physicians and to consider the following factors—

- Inflation.
- Changes in the number and age composition of Medicare enrollees under Part B (excluding risk health maintenance organization (HMO) enrollees).
- Changes in technology.
- Evidence of inappropriate utilization of services.
- Evidence of lack of access to necessary physician services.
- Other appropriate factors as determined by the Secretary.

The Secretary recommended performance standard rates of increase for FY 1992 of 4.1 percent for surgical services, 7.1 percent for nonsurgical

services, and 6.2 percent for all physician services. As required by section 1848(f)(1)(B) of the Act, the Physician Payment Review Commission reviewed the Secretary's recommendations and it recommended performance standard rates of increase for FY 1992 of 6.6 percent for surgical services, 9.6 percent for nonsurgical services, and 8.6 percent for all physician services.

If Congress does not set the performance standard rates of increase, sections 1848(f)(2) (A) and (B) of the Act specify a formula for the Secretary to determine the performance standard rates of increase. Section 1848(f)(1)(C) of the Act requires the Secretary to publish in the *Federal Register* in the last 15 days of October of each year the performance standard rates of increase for all physician services and for each category of physician services for the Federal fiscal year that began on October 1st of that year. For example, in the last 15 days of October 1991, the physician performance standard rates of increase for FY 1992 must be published.

Under sections 1848(f)(2) (A) and (B) of the Act, unless revised by Congress, the physician performance standard rates of increase for FY 1992 for all physicians' services and for each category of physician services equal the product of the following components minus 1.0, multiplied by 100 and reduced by 1.5 percentage points:

- 1.0 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in fees for all physician services or for the category of physicians' services for the portions of CY 1991 and CY 1992 contained in FY 1992.
- 1.0 plus the Secretary's estimate of the percentage increase or decrease (divided by 100) in the average number of Part B enrollees (excluding risk HMO enrollees) from FY 1991 to FY 1992.
- 1.0 plus the Secretary's estimate of the average annual percentage growth (divided by 100) in volume and intensity of all physician services or of the category of physicians' services for FY 1987 through FY 1991.
- 1.0 plus the Secretary's estimate of the percentage increase or decrease (divided by 100) in expenditures for all physician services or of the category of physicians' services that will result from changes in law or regulations in FY 1992 as compared with expenditures for physician services in FY 1991.

II. Provisions of this Notice

A. Physician Fee Schedule Update

Under the requirements of section 1848(d)(3) of the Act, the fee schedule update for CY 1992 will be 1.9 percent. We determined this update as follows:

- Our estimate of the CY 1991 MEI increase is 3.2 percent.
- Under section 1848(d)(3)(A)(iii) of the Act, we then reduced our estimate of the MEI increase by 0.4 percentage points.
- Next, we subtracted an additional 0.9 percentage points from the reduced MEI increase to take into account the percentage by which FY 1990 expenditures exceeded the FY 1990 performance standard rate of increase. In FY 1990, expenditures increased 10.0 percent, or 0.9 percentage points more than the performance standard rate of increase.

B. Physician Performance Standard Rates of Increase for FY 1992

Under the requirements in sections 1848(f)(2) (A) and (B) of the Act, we have determined that the performance standard rates of increase for physician services for FY 1992 are 6.5 percent for surgical services, 11.2 percent for nonsurgical services, and 10.0 percent for all physician services. This determination is based on the following factors:

1. The weighted average percentage increase in fees (before applying legislatively mandated reductions which are included below under factor 4) for physician services for months of CY 1991 and CY 1992 contained in FY 1992 is 3.9 percent for surgical services, 4.1 percent for nonsurgical services, and 4.0 percent for all physician services.
2. The percentage increase in the average number of Part B enrollees from FY 1991 to FY 1992 (excluding risk HMO enrollees) is 1.3 percent for surgical services, nonsurgical services, and all physician services.
3. The average annual growth in volume and intensity of physician services for FY 1987 through FY 1991 is 8.1 percent for surgical services, nonsurgical services, and all physician services.
4. The percentage increase in expenditures for physician services resulting from changes in law or regulations in FY 1992 as compared with FY 1991 is —5.1 percent for surgical services, —1.1 percent for nonsurgical services, and —2.1 percent for all physician services.
5. The performance standard factor specified by section 1848(f)(2)(B) of the Act is 1.5 percentage points.

Substituting these numbers in the formula described above results in the following factors:

Factor 1—This factor equals 1.039 for surgical services, 1.041 for nonsurgical services, and 1.040 for all physician services.

Factor 2—This factor equals 1.013 for surgical services, nonsurgical services, and all physician services.

Factor 3—This factor equals 1.081 for surgical services, nonsurgical services, and all physician services.

Factor 4—This factor equals 0.949 for surgical services, 0.989 for nonsurgical services, and 0.979 for all physician services.

The product of these four factors is 1.08 or 8.0 percent for surgical services, 1.127 or 12.7 percent for nonsurgical services, and 1.115 or 11.5 percent for all physician services. Subtracting the performance standard factor of 1.5 percentage points yields performance standard rates of increase of 6.5 percent for surgical services, 11.2 percent for nonsurgical services, and 10.0 percent for all physician services.

C. Physician Services

Section 1848(f)(5)(A) of the Act defines physician services for purposes of the volume performance standard rates of increase as including other items or services (such as clinical diagnostic laboratory tests and radiology services), as specified by the Secretary, that are commonly performed by a physician or furnished in a physician's office. Section 1861(s) of the Act defines medical and other health services covered under Part B. As provided for in the FY 1990 performance standard rates of increase notice in the **Federal Register** on December 29, 1989 (54 FR 53819), we are continuing to include the following medical and other health services under section 1861(s) of the Act in the physician performance standard rates of increase if bills for the items are processed and paid for by Medicare carriers:

- Physician services.
- Services and supplies furnished incident to physician services.
- Outpatient physical therapy and speech therapy services, and outpatient occupational therapy services.
- Antigens prepared by or under the direct supervision of a physician.
- Services of physician assistants, certified registered nurse anesthetists, certified nurse midwives, clinical psychologists, clinical social workers, nurse practitioners and clinical nurse specialists.
- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests.

- X-ray, radium, and radioactive isotope therapy.

- Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations.

Many diagnostic services, such as diagnostic x-ray and diagnostic laboratory tests, are furnished in outpatient departments of hospitals. Except for medically necessary physician interpretations of the tests, these tests are not paid on a reasonable charge basis or fee schedule basis by carriers, but are paid by intermediaries. Much of the detailed information needed to set performance standard rates of increase is not available for diagnostic services when furnished by a hospital. The data are included in hospital cost reports and are not readily available under current data collection systems. As data systems evolve in response to setting physician performance standard rates of increase, we may consider including diagnostic x-ray, laboratory, and other services furnished in hospital outpatient departments in setting future performance standard rates of increase.

The other items and services for which significant payments are made under Part B are durable medical equipment, ambulance services, and services furnished by ambulatory surgical centers. We did not include these items and services in the performance standard rates of increase because they are not commonly furnished by a physician or performed in a physician's office. However, we intend in the future to consider more fully whether any of the services furnished under part B that are not covered in this notice should be included.

D. Definition of Surgical Services

On May 3, 1990, we published in the **Federal Register** a notice with comment period (55 FR 18668) that announced the definition of surgical services for purposes of the performance standard rates of increase for expenditures and volume of physician services and the appropriate fee schedule updates as required by section 1848(j) of the Act. Surgical services were defined as follows:

- All services that are both currently classified as type of service "surgery" and that are performed by surgical specialists. Surgical specialists include the following specialists:
 - General surgeon
 - Neurological surgeon
 - Obstetrician
 - Gynecologist
 - Ophthalmologist
 - Oral surgeon
 - Orthopedic surgeon

—Otorhinolaryngologist
 —Plastic surgeon
 —Proctologist
 —Thoracic surgeon
 —Urologist
 —Podiatrist
 —Dermatologist
 —Hand surgeon
 —Multispecialty clinic

• All services currently classified as type of service "assistant at surgery".

This definition includes procedures recognized in the surgical section of Current Procedural Terminology published by the American Medical Association, and certain other invasive procedures, and this definition would not lead to payment differentials by physician specialty. Any differential in annual updates because of separate performance standard rates would be procedure-specific without regard to specialty.

III. Calculation of CY 1992 Physician Fee Schedule Update

Below is an explanation of the individual factors used to determine the physician fee schedule update.

A. The Percentage Change in the MEI

The MEI is a measure of inflation in selected expenses that are relevant to physicians in office practice. Two expense categories comprise the MEI. The physician practice expense category includes employee wages, rents, transportation, drugs and medical supplies, malpractice insurance, and other miscellaneous expenses. The physicians' general earnings (net income) includes increases in earnings less increases in productivity of nonfarm workers. The individual components which comprise the MEI are as follows:

Annual percent change of the components of the Medicare Economic Index ¹	Percent change ²
1. Hourly earning of non-supervisory workers in finance, insurance, and real estate ³	4.8
2. Housing component of the consumer price index.....	4.4
3. Private transportation component of the consumer price index.....	6.1
4. Drugs and pharmaceutical component of the consumer price index.....	6.4
5. All other, miscellaneous, expenses (tied to the entire consumer price index).....	5.3
6. Premiums for malpractice insurance ⁴	-9.7
7. Average weekly earnings of production and nonsupervisory workers ³	3.0
8. Index of output per man hour of employed nonfarm workers ³	0.0
9. Change in average weekly earnings net of change in output per man hour.....	3.0

¹ The weights for the MEI components, including the malpractice component were derived from a special study done for HCFA by a consultant in 1982. The values are 0.47, 0.23, 0.07, 0.09, 0.04

and 0.10 for components one through six, respectively. In addition to the above weights, a 40-60 percent breakdown of gross income between physician practice expenses and physician earnings was used.

² The rates of change are for the 12-month period ending June 30, 1991. The same base period is used for computing customary and prevailing charges.

³ Figures are published monthly in the Bureau of Labor Statistics' Monthly Labor Review.

⁴ Derived from a survey of several major insurers (latest available percent change data are for CY 1989 through CY 1990). This is consistent with prior computations of the malpractice insurance component of the MEI.

On September 9, 1991, we published a proposed rule (at 56 FR 45926) that would revise the methodology for determining the MEI increase, which had not undergone a major methodological revision since its adoption in 1975. We proposed to revise the method used to calculate the MEI in order to more accurately reflect year-to-year economic changes affecting the cost of providing physician services. In general, the new methodology we proposed would:

- Adopt a specific type of index (Lespeyres) to measure changes;
- Use data more current than the CY 1977 data used in the current index;
- Develop revised expense categories to reflect more accurately expenses that physicians currently incur; and
- Select price proxies that are more relevant for the revised cost categories.

We are unable to use the proposed methodology for CY 1992 since we have not published a final rule. However, we plan to analyze any comments received on the proposed rule and publish a final rule that will include and explain fully any new MEI calculation methodology that would be used in determining the CY 1993 physician fee schedule update.

Our estimate of the MEI increase for CY 1992 is 3.2 percent. However, under section 1848(d)(3)(A)(iii) of the Act, which provides for a 0.4 percentage point reduction in the update index increase for CY 1992, we are reducing the MEI increase to 2.8 percent.

B. Adjustment in Update

As required by section 1848(d)(3)(B)(i) of the Act, we reduced the MEI by 0.9 percentage points to reflect that the percentage increase in expenditures between FY 1989 and FY 1990 exceeded the performance standard rate of increase for FY 1990.

Our estimate of the percentage growth in physicians' services between FY 1989 and FY 1990 is 10.0 percent for all physician services. Because the performance standard rate of increase for FY 1990 was 9.1 percent, the rate of increase in physicians' services exceeded the performance standard rate of increase by 0.9 percentage points.

IV. Calculation of FY 1992 Physician Performance Standard Rates of Increase

Below we have explained how we determined the increases for each of the four factors used in determining the performance standard rates of increase for FY 1992.

Factor 1—Weighted Average Percentage Increase in Fees for Physician Services (before applying legislatively mandated reductions) for Months of Calendar Years 1991 and 1992 included in FY 1992.

This factor was calculated as a weighted average of the fee increases that apply to FY 1992; that is, the fee increases that apply to the last 3 months of CY 1991 multiplied by 25 percent plus the fee increases that apply to the first 9 months of CY 1992 multiplied by 75 percent. Physician services are updated by increases in the MEI for FY 1991 and by a physician fee schedule update factor for FY 1992. As explained in section III.B above, the update factor for FY 1992 is the MEI increase adjusted by the percentage that the percentage increase in expenditures in FY 1990 compared to FY 1989 exceeded the performance standard rate of increase for FY 1990. Laboratory services are updated by increases in the Consumer Price Index for Urban Consumers (CPI-U). However, for CY 1991 through CY 1993, section 1833(h)(2)(A)(ii)(III) of the Act establishes the update for laboratory services as 2.0 percent. Table 1 shows the updates that were used to determine the weighted average percentage increase in physician fees.

TABLE 1.—MEDICARE PAYMENT UPDATES AND ESTIMATED INCREASES IN THE MEI AND CPI-U FOR FY 1991 AND FY 1992

Service	MEI	Physician fee schedule update factor	Laboratory	
	1991	1992	1991	1992
Physician Primary Care ¹	2.0	1.9		
Radiology, anesthesiology, and overpriced procedures ²	0.0	1.9		
Other.....	0.0	1.9		
Laboratory.....			2.0	2.0

¹ Primary care services are defined as office visits, emergency room visits, home visits, and nursing home visits.

² Overpriced procedures are the approximately 250 procedures described in section 1842(b)(14)(C)(i) of the Act.

Physician services make up 94 percent of the total expenditures in the definition of physician services used for

purposes of the performance standard rates of increase, and laboratories services represent 6 percent. Within the 94 percent attributed to physician services, 15 percent is for primary care services.

In addition to the annual updates and individual weights of the above services, three other elements have a significant effect on the rate of increase in reasonable charges. First, section 1848(d)(3)(A)(iii) of the Act reduced our MEI estimate by 0.4 percentage points. This has the overall effect of reducing the rate of increase.

Second, actual and customary charges below prevailing charge levels are not constrained by the MEI and may increase at a faster rate than prevailing charges. Thus, overall reasonable charge increases have historically been greater than MEI increases. We included a factor to account for the effect of increases in both actual and customary charges in performance standard rates of increase for prior years. However, for FY 1992, this factor includes only the effect of increases in actual charges for all services and customary charges for primary care services. This is because section 1842(b)(4)(B)(iv) of the Act, as added by section 4105(a)(2) of Pub. L. 101-508, provided for updates in customary charges for calendar year 1991 for primary care services only. This will only be a factor for October through December 1991, the months of CY 1991 contained in FY 1992. This will not be a factor for the 9 months of FY 1992 contained in calendar year 1992

because, effective January 1, 1992, the current reasonable charge system will be replaced by the new fee schedule in which customary charges will no longer apply. The final rule implementing the new physician fee schedule will be published in the *Federal Register* before the January 1, 1992 implementation date.

Third, section 1842(h)(1) of the Act provides for "participating physicians," who, in addition to billing Medicare directly for their services, agree to accept Medicare payment as payment in full, and to bill Medicare beneficiaries only for the 20 percent coinsurance amount and any unmet portion of the \$100 annual deductible amount. Sections 1842(b)(4)(A)(iv) and 1848(a)(3) of the Act provides that nonparticipating physicians are paid 5 percent less for their Medicare services than participating physicians. Physicians are given an opportunity at the end of each calendar year to enroll as a participating physician for the next calendar year. Participation rates have increased each year, and we assume that this trend will continue. The increase in the number of

participating physicians and the fact that they are paid at a rate higher than nonparticipating physicians also add to the rate of increase in reasonable charges.

Due to the provision in section 4118(e) of Public Law 101-508 that amended section 1848(f)(2)(A)(iv) of the Act, this factor now shows the fee increases prior to applying legislated reductions to the MEI or CPI. After taking into account all the elements described above, we estimate that the weighted average increase in fees for physicians services in FY 1992 before applying legislatively mandated reductions will be 3.9 percent for surgical services, 4.1 percent for nonsurgical services, and 4.0 percent for all physician services.

Factor 2—The Percentage Increase in the Average Number of Part B Enrollees from FY 1991 to FY 1992

We estimate that average Medicare Part B enrollment in FY 1992 will be 33.404 million. Decreasing that figure by the estimated enrollment in risk HMOs of 1.382 million results in an estimate of 32.022 million nonrisk HMO Part B enrollees in FY 1992.

The corresponding figures for FY 1991 are estimated to be 32.880 million total Part B enrollees and 1.280 million risk HMO enrollees, which results in an estimate of 31.600 million Part B enrollees not in risk HMOs. We estimate that there will be 0.422 million more Part B enrollees not in risk HMOs in FY 1992 than in FY 1991, which represents a 1.3 percent increase from FY 1991 to FY 1992.

Factor 3—Average Annual Growth in Volume and Intensity of Physician Services for FY 1987 through FY 1991

Section 1848(f)(2)(A)(iii) of the Act requires the Secretary to estimate the average annual percentage growth in volume and intensity of physician services for FY 1987 through FY 1991. This estimate is to be based upon information contained in the most recent annual report issued by the Board of Trustees of the Supplementary Medical Insurance Trust Fund (Trustees Report).

The data on the percentage increase in the volume and intensity in the Trustees Report are based on historical trends in increases in reasonable charges. However, the performance standard rates of increase under this notice are to be applied against increases in expenditures; that is, incurred benefits. The \$75 Part B deductible remained the same throughout the 1987 through 1990 period. The deductible was raised from \$75 to \$100 by section 1833(b) of the Act as amended by section 4302 of Public Law 101-508 effective January 1, 1991.

Although both reasonable charges and expenditures have been increasing over this period, the average rate of increase in expenditures was larger in the FY 1987 through FY 1990 period than the average rate of increase in reasonable charges. This difference is due to the deductible remaining at \$75 during this period. However, for the FY 1990 through FY 1991 period, the average rate of increase in reasonable charges was larger than the average rate of increase in expenditures due to the deductible being raised from \$75 to \$100.

Although we believe it would be consistent with a literal interpretation of section 1848(f)(2)(A)(iii) of the Act, it would be inappropriate to base the volume and intensity component on the 5-year growth in reasonable charges because of the effect of the deductible. We believe the most equitable approach is to compute the 5 year average annual increase based on reasonable charges, which is 7.4 percent, and to adjust it by a factor that would account for the estimated effect of the deductible on expenditure growth in FY 1992 as compared with FY 1991. This equates to 0.7 percent, which added to 7.4 percent, yields an increase of 8.1 percent.

Consistent with data contained in the Trustees Report, we estimated this component of the performance standard rates of increase using a definition of physician services that includes certain supplies and nonphysician services not otherwise included in computing the performance standard rates of increase (primarily durable medical equipment (DME) and ambulance services). We included data for these services because we were required to base the estimate on data contained in the Trustees Report, and it was not feasible to recompute the data from the five-year period to exclude these supplies and nonphysician services. We believe the inclusion of these nonphysician supplies and services in this component has a minimal effect on the estimate because the component measures rates of change. Since DME and ambulance services constitute only about 10 percent of the total charges used in the Trustees Report, the rate of change for these nonphysician services and supplies would have to be significantly different from the rate of change for physician services to have any measurable impact on this volume and intensity increase factor. The volume increases for services performed in independent laboratories were included in the calculation of the physician increases. (We want to emphasize that Factor 3 is the only component of the performance standard rate of increase that was

estimated using data that included nonphysician services and supplies.)

Factor 4—Percentage Increase in Expenditures for Physician Services Resulting from Changes in Law or Regulations in FY 1992 Compared with FY 1991

Legislative changes enacted in Public Law 101-508 and the implementation of the physician fee schedule will have an impact on the performance standard rates of increase for FY 1992.

It is estimated that the provisions in Public Law 101-508 and implementation of the physician fee schedule will result in aggregate decreases in FY 1992 of 1.1 percentage points for nonsurgical services and 5.1 percentage points for surgical services. An increase in the beneficiary deductible required by section 1833(b) of the Act as amended by section 4302 of Public Law 101-508 had the effect of reducing the performance standard rates of increase for both nonsurgical and surgical services. In addition, the performance standard for both surgical and nonsurgical services was reduced by the provision in section 1842(b)(16) of the Act as amended by section 4101(b) of Public Law 101-508 that required reductions in prevailing charges and by the provision in section 4109 of Public Law 101-508 that prohibits separate payments for interpretation of electrocardiograms performed or ordered in conjunction with an office visit. In Public Law 101-508, provisions that primarily affected surgical services resulted in reduced payments for overvalued procedures, reduced prevailing charges for other procedures and reduced payments for assistants at surgery. Provisions that primarily had the effect of increasing the performance standard for nonsurgical services include program expansions required by provisions in Public Law 101-508 such as coverage of screening mammography services, additional coverage of nurse practitioner services, and provisions affecting payments to certified registered nurse anesthetists.

In addition, we expect that implementation of the physician fee schedule will increase payment rates and, therefore, will increase the performance standard for nonsurgical services. Similarly, the new fee schedule will reduce payment rates for most surgical services and thus reduce the performance standard rate of increase for surgical services. However, implementation of the fee schedule will have no effect on the performance standard rate of increase for all physician services because section 1848(d)(1)(B) of the Act requires that implementation of the physician fee

schedule be budget neutral in CY 1992. That is, payment rates must be determined so that outlays for physician services under the new system equal the outlays that would have occurred under the old system. It should be noted that the legislated decreases in physician fee updates are now included in this factor due to an amendment contained in section 4118(e) of Public Law 101-508.

We should also note that our estimate of savings from these legislative proposals includes the actuarial assumption that there is a response to reductions in fees so as to offset about half of the budget savings that would otherwise be achieved. Because this assumption has the effect of increasing our estimate of expenditures, the performance standard is significantly increased to the benefit of the physicians. If we had not made this assumption, we estimate that the performance standard rates of increase would have been reduced by an additional 2.6 percentage points for all physician services, 2.5 percentage points for nonsurgical services and 3.1 percentage points for surgical services.

V. Regulatory Impact Statement

Executive Order (E.O.) 12291 requires us to prepare and publish a regulatory impact analysis for any notice that meets one of the E.O. 12291 criteria for a "major rule"; that is, that will be likely to result in—

- An annual effect on the economy of \$100 million or more;
- A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- Significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612) unless the Secretary certifies that a notice will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, States and individuals are not entities, but we consider all physicians to be small entities.

We have determined that this notice, in itself, will not produce any effects that will meet any of the criteria of E.O. 12291 or of the RFA since this notice merely announces the Medicare physician performance standard rates of increase for FY 1992 as set forth in sections 1848(f)(2) (A) and (B) of the Act

and the fee schedule update for CY 1992 as set forth in section 1848(d)(3) of the Act. Any effects that result from this notice are the result of the statutory provisions and not this notice. Therefore, we have determined that neither a regulatory impact analysis under E.O. 12291 nor a regulatory flexibility analysis under the RFA are required. For the same reasons, we have determined, and the Secretary certifies, that this notice will not have a significant effect on a substantial number of small entities.

Section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis if a notice may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital which has fewer than 50 beds and is located outside of a Metropolitan Statistical Area.

We are not preparing a rural impact statement since we have determined, and the Secretary certifies, that this notice will not have a significant economic impact on the operations of a substantial number of small rural hospitals.

VI. Other Required Information

A. Waiver of 30-Day Delay in Effective Date

We usually provide a delay of 30 days in the effective date for documents such as this. However, in this case, the performance standard rates of increase are required by law to be published in the last 15 days of October 1991 and are effective on October 1, 1991. Thus, Congress has clearly indicated its intent that the rates of increase be implemented without the usual 30-day delay and has foreclosed any discretion by HCFA in this matter. Therefore, we find good cause to waive the 30-day delay. With regard to the physician fee schedule update, the effective date will be January 1, 1992, which is more than 30 days beyond the publication date of this notice.

B. Paperwork Reduction Act

This notice does not impose paperwork or information collection requirements. Consequently, it need not be reviewed by the Executive Office of Management and Budget under the authority of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501-3511).

(Section 1848(f) of the Social Security Act)

(Catalog of Federal Domestic Assistance
Program No. 13.774, Medicare—
Supplementary Insurance Program)

Dated: October 22, 1991.

Gail R. Wilensky,

*Administrator, Health Care Financing
Administration.*

Approved: November 1, 1991.

Louis W. Sullivan,

Secretary.

[FR Doc. 91-27785 Filed 11-15-91; 9:30 am]

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Federal Register

Monday
November 25, 1991

Part III

United States Information Agency

22 CFR Part 514

Exchange Visitor Program; General
Provisions and Training Programs; Notice
of Proposed Rulemaking

UNITED STATES INFORMATION AGENCY**22 CFR Part 514****[Rulemaking No. 5]****General Provisions, the Exchange Visitor Program**

AGENCY: United States Information Agency.

ACTION: Notice of proposed rulemaking.

SUMMARY: By this notice the Agency is proposing regulations governing the general provisions of the Exchange Visitor Program to replace the present regulations. The Agency has undertaken a thorough review of the Program, its enabling legislation, and past history. This review has, in turn, directed the Agency upon a course of regulatory and management practice reform. The amendments to 22 CFR part 514 set forth in detail below are proposed in an effort to define more clearly the obligations, duties and relationships of the Agency, sponsors, and exchange participants.

DATES: Comments on the proposed rule will be accepted until February 24, 1992. All written communications received by the Agency on or before the closing date will be considered by the Agency before it takes action on a final rule.

ADDRESSES: Please submit five copies of written comments to: Rulemaking No. 5, Merry Lynn, Assistant General Counsel, Office of the General Counsel, room 700, United States Information Agency, 301 Fourth Street, SW., Washington, DC 20547.

FOR FURTHER INFORMATION CONTACT: Merry Lynn, Assistant General Counsel, (202) 619-6829.

SUPPLEMENTARY INFORMATION: The Director of the United States Information Agency ("Agency") is authorized to facilitate and direct educational and cultural exchange activities in order to develop and promote mutual understanding between the people of the United States and other countries of the world. Now governed by the provisions of the Mutual Educational and Cultural Exchange Act of 1961 ("Fulbright-Hays Act"), educational and cultural exchange is the cornerstone of United States public diplomacy efforts.

First begun pursuant to the provisions of the United States Information and Educational Exchange Act of 1948 ("Smith-Mundt"), and subsequently incorporated into and broadened under the Fulbright-Hays Act, educational and cultural exchange activities have, over the past forty years, exposed millions of foreign nationals to the United States,

its culture, philosophy, business techniques, and educational institutions. The Fulbright-Hays Act mandates reciprocal exchange and Americans travelling abroad have, in similar fashion, developed an enhanced awareness of foreign people, their cultures and societies. Originally administered by the Department of State, oversight of exchange activities, occurring under the umbrella of the Exchange Visitor Program, has been the responsibility of the Agency since 1978.

The Exchange Visitor Program is facilitated—indeed, largely conducted—by Agency designated program sponsors who are responsible for the recruitment, placement, and supervision of exchange participants. Pursuant to Congressional mandate, utilization of private sector expertise and resources has resulted in the designation of over 5,000 exchange visitor programs during the past forty years. Currently, in excess of fifteen hundred program sponsors are conducting exchange activities. In 1989, these Agency-designated sponsors facilitated the entry into the United States of more than 170,000 exchange program participants.

Though widely hailed as an innovative and successful foreign policy initiative, the Exchange Visitor Program is not without flaw. Debate concerning the parameters of program participation and activity has arisen in recent years. In response to this debate, the Agency has undertaken a thorough review of the Program, its enabling legislation, and past history. This review has, in turn, directed the Agency upon a course of regulatory and management practice reform. The amendments to 22 CFR part 514 set forth in detail below are proposed in an effort to define more clearly the obligations, duties and relationships of the Agency, sponsors, and exchange participants.

Definitions

To assist the exchange community in review of these proposed regulations, the Agency has incorporated into this Rulemaking the definitions currently set forth at 22 CFR 514.1. Minor changes, not affecting underlying meaning, have been made to most of the definitional terms. Such changes, when made, are proposed in an effort to enhance overall clarity and readability. Although definition of the term "citizenship" was the subject of a separate rulemaking, such term is also included here, in final form, to facilitate overall review. As discussed in detail below, definitions of the terms "accredited educational institution," "full course of study," and "student" are introduced for comment. Such terms are offered for definitional

purposes. Application and interpretation of these terms will be discussed in future rulemakings.

8 U.S.C. 1101(a)(15)(J) provides, in part, that an exchange visitor may enter the United States under the aegis of a J-visa if such visitor is a *bona fide* student actively engaged in *bona fide* academic study. 22 U.S.C. 2460(b) directs the Agency to ensure that exchange visitor programs sponsored by its Bureau of Educational and Cultural Affairs are of the highest academic standards. Pursuant to these statutes, Agency stewardship of the Exchange Visitor Program requires that the *bona fides* of an exchange visitor's academic studies be ascertained. In order to quantify *bona fide* academic study and enhance Agency administration and oversight of the Exchange Visitor Program, definitions of the terms "accredited educational institution," "full course of study," and "student" are proposed.

Agency regulations set forth at 22 CFR 514.2(a) specify that an Exchange Visitor Program participant may be a "student" pursuing formal courses leading to a recognized degree at an "established school or institution of learning." Current Agency regulations do not define these terms. In order to comply with its legislative mandate to ensure the *bona fides* of academic study undertaken within the purview of the Exchange Visitor Program, the Agency proposes to: (i) Define the *bona fides* of an educational institution by way of its accreditation status; and (ii) define the *bona fides* of student status in terms of attendance at an accredited educational institution and successful completion of the minimum number of academic credits per semester which best evidences full-time study.

It is Agency opinion and belief that accreditation is an objective and independent measurement of the *bona fides* of an "established school or institution of learning." Evidence of Agency policy and practice regarding accreditation is set forth at the current 22 CFR 514.15. This regulation authorizes the Agency to require evidence of accreditation from applicants seeking sponsor designation under the Exchange Visitor Program. The absence of a specific definition concerning accreditation was, in part, the basis of recent litigation. This litigation arose due to an Agency determination that a non-accredited educational institution was not an appropriate sponsor within the purview of the Exchange Visitor Program. Although the Agency prevailed in this litigation, the Agency now desires to amend existing regulations explicitly to

enunciate the Agency's accreditation policy.

Recognizing that the expertise for determining accredited educational institutions lies with various independent accrediting authorities, the proposed Agency definition makes provision for the use of such findings on accreditation made by these independent authorities. Specifically, in review of the *bona fide* status of an educational institution, the Agency proposes to utilize the annual listing of accreditation authorities promulgated by the Secretary of Education pursuant to 20 U.S.C. 1141(a). As explained in 34 CFR 602.1 accreditation is both a prerequisite to eligibility for various types of Federal financial assistance and a reliable measure concerning the quality of education offered by an educational institution. Agency use of such annual listing is also appropriate given the Department of Education's expertise and responsibility for oversight and implementation of Federal education initiatives. Pursuant to the proposed definition, academic study completed at a non-accredited educational institution will not be deemed to comply with the *bona fide* requirement set forth in 8 U.S.C. 1101(a)(15)(J).

A *bona fide* student must, by implication, be actively engaged in the pursuit of *bona fide* academic study. To assist in determination of what constitutes *bona fide* study, the Agency has surveyed the catalogues of various educational institutions regarding their criteria for full-time student status. The results of this survey indicate that current practice in the field of higher education generally requires an enrolled full-time student to pursue a minimum of twelve semester hours of undergraduate or nine semester hours of graduate academic credits each semester. This minimum course load is considered satisfactory evidence of appropriate advancement toward degree completion and is commonly used as the measure for payment of full-time tuition. Further, the Agency has also examined Immigration and Naturalization Service regulations set forth at 8 CFR 214.2(f)(6). This regulation, first promulgated by publication at 40 FR 32312 (1975), requires an undergraduate student to complete a minimum of twelve semester hours of academic credit (or equivalent) per semester of attendance and a graduate student to complete the minimum number of credits per semester which an appropriate school official certifies as a full course of study.

Based upon the above information, the Agency concludes that pursuit of *bona*

fide study is best evidenced by a student's successful completion of a minimum number of academic credits per semester. Pursuant to the *bona fide* requirements of 8 U.S.C. 1101(a)(15)(J), the Agency has determined that an exchange visitor entering the United States as a "student" under the J-visa must be actively engaged in the pursuit of a "full course of study." Accordingly, successful completion of not less than twelve semester hours of academic credit (or its equivalency) per academic term while pursuing an undergraduate degree, and successful completion of not less than nine semester hours of academic credit (or its equivalency) per academic term while pursuing graduate course work is proposed as the Agency's objective measure of *bona fide* study. Additional regulations governing college and university students will address various issues arising from application of this standard, such as illness and failure, and provide certain flexibility in its application. Secondary school student exchange participants shall meet the full course of study requirement by enrollment in the minimum number of classes prescribed by their local school district.

In response to a perceived need in the academic community the Agency proposes to expand student status to encompass participation in a specialized program of instruction of less than one year's duration. Such program shall be conducted under the aegis of an accredited educational institution and must be comprised of a structured course of study devoted to a particular academic endeavor. An example of such a program would include an interdisciplinary course of study in arts management comprised of courses offered by the fine arts, business, public administration and law schools of a given academic institution.

Exchange Participants and Activities

Acting in response to Congressional request, the Government Accounting Office ("GAO") investigated Agency oversight and administration of the Exchange Visitor Program and its attendant utilization of the J-visa. In its report to Congress, dated February 5, 1990 and entitled "Inappropriate Uses of Educational and Cultural Exchange Visas," the GAO determined that certain Exchange Visitor Program activities appeared to be inconsistent with the statutory grant of authority and its underlying legislative intent. GAO summarized its findings, stating:

Most J-visa activities appear to conform to the intent of the 1961 act. However, GAO believes that certain activities and programs in the trainee and the international visitor

categories, including the summer student/travel work, international camp counselor, and au pair (childcare) programs, are inconsistent with legislative intent. GAO identified instances of participants working as waiters, cooks, child care providers, amusement and leisure park workers, and summer camp counselors. Authorizing J-visas for participants and activities that are not clearly for educational and cultural purposes as specified in the act dilute the integrity of the J-visa and obscures the distinction between the J-visa and other visas granted for work purposes.

Report, p. 3

In turn, Agency response to this justifiable criticism began with a thorough review of enabling legislation authorizing the Exchange Visitor Program and admission into the United States of foreign nationals on a J-visa.

The Fulbright-Hays Act prescribes categories of eligible exchange participants. The Act provides for the exchange of students, scholars, trainees, teachers, professors, researchers, specialists, leaders in a specialized field of knowledge or skill, or other person of similar description. In addition, the Act requires that exchange participants participate in *bona fide* teaching, study, instruction, lecturing, observation, consultation, research, training or demonstration of special skill activities. Further, the Act authorizes non-immigrant aliens falling within the statutory parameters of the Act to enter the United States under the aegis of a J-visa for the purpose of participation in an exchange visitor program. The amendments to 22 CFR part 514 set forth below at § 514.3 and § 514.4 are proposed in an effort to define the criteria governing Program eligibility of both sponsors and exchange visitors.

The Agency will require sponsors to be both United States citizens as such term is defined in this Part and to affirmatively demonstrate an ability to comply, and remain in continual compliance, with all regulatory provisions. As regards exchange visitors, the Agency has defined the statutorily enumerated categories of eligible participation in terms of the activity inherent to each categorical status. Thus, by way of illustration, the Agency has determined that an eligible "student" exchange participant is one entering the United States for the purpose of pursuing a full course of study at an accredited educational institution. This approach will ensure that exchanges occurring under the aegis of the Exchange Visitor Program fall squarely within the established statutory parameters of status and activity. As participation in the Exchange Visitor Program is thus

limited, strict adherence and compliance with Agency promulgated definitions of status will be expected.

In review of both enabling legislation and long-standing Agency policy, a determination has been made that camp counselor programs do in fact fall within existing statutory parameters. This determination is at variance with a GAO report suggesting that international camp counselor programs are inconsistent with the legislative intent of the Fulbright-Hays Act. The Agency has determined, however, that such programs are authorized pursuant to both the express language of the statute and its underlying legislative history.

International camp counselor is not a statutorily enumerated category of exchange participation. Camp counselor exchange participants must, however, as a prerequisite for participation, be "students" in their home country. In light of this prerequisite, these participants fall squarely within the statutorily authorized category of "other person of similar description." As regards activities while in the United States, camp counselors are actively engaged in teaching, observation, and instruction activities. Given the directive of broad interpretation found in the legislative history of the Fulbright-Hays Act, Agency designation of these programs is clearly consistent with the statutorily enumerated purpose and objective of the legislation. To avoid confusion as to the categorization of camp counselor program participants, a new category, set forth at § 514.4 as a subpart of "other persons of similar description," is proposed.

Also set forth in § 514.4 as subparts of the "other persons of similar description" participant category are "International Visitor" and "Government Visitor." Originally intended only for Agency use, the International Visitor category has devolved to "catch-all" usage over the years. As proposed, reservation of this category only for Agency use will allow definitive and statistical illustration of the nature and scope of exchanges occurring under direct Agency sponsorship. Similar in nature to International Visitor, the proposed Government Visitor category will be utilized for exchanges directly sponsored by local, state, or federal government agencies.

In addition to delineating sponsor and participant eligibility criteria, the Agency proposes that all exchange programs designated by the Agency meet certain eligibility requirements. As set forth at § 514.8, the Agency has determined that all programs should

have not less than five exchange participants annually. Further, with the exception of programs for the newly defined "scholar" participant, all programs must provide for cross-cultural activities and afford all exchange participants a stay in the United States of not less than three weeks. These requirements are currently set forth in existing regulations, but have, along with a requirement for reciprocity, been reordered and will henceforth be prerequisites to program designation.

A regulatory requirement addressing the Agency's long-standing reciprocal exchange policy is set forth in § 514.8. Such policy requires exchange sponsors to facilitate reciprocal exchange of persons to the fullest possible extent. Statutorily mandated, reciprocity is inherent in the concept of mutual exchange of persons. Confusion over the nature and scope of reciprocity has been problematic for some time. As a policy consideration, the Agency seeks to promote and foster innovative and expansive responses to this critical program requirement. By way of illustration, the Agency will view with favor a proposal to satisfy the reciprocity requirement through the exchange of teachers for students or trainers for trainees.

Although one-for-one exchange is the ultimate objective of the foreign policy underlying passage of the Act, the Agency recognizes that circumstances may permit no, or only limited, reciprocal exchange opportunities. In such circumstances the Agency will determine in review of a pending application, whether the exchange activity nevertheless furthers the purposes of the Fulbright-Hays Act.

Related to reciprocity is the requirement that exchange visitors be exposed to various activities designed to promote cross-cultural awareness. Sponsors will be required to facilitate an exchange participant's involvement in community sports, cultural, and social activities for the purpose of enhancing the participant's knowledge and understanding of American mores, customs, and way of life.

Program Designations

Agency self-examination of its administration of the Exchange Visitor Program has resulted in a determination that certain internal program controls should be bolstered. In part, the Agency has determined that sponsor application and designation procedures should be strengthened and more clearly delineated. To this end, the Agency proposes, pursuant to provisions set forth at § 514.5 and § 514.6, amendment of existing application and designation

procedures and the addition of a new requirement dictating periodic redesignation.

Confusion concerning the actual number of Agency-designated Exchange Visitor Program sponsors was an initial area of GAO investigation and proved a fertile source of criticism. Actual determination of this number proved problematic given both Department of State and Agency failure to cancel sponsor designations due to program inactivity or abandonment. This failure is best illustrated by the fact that of over 5,400 programs designated in the last forty years, less than a third are operating today. Through utilization of its Exchange Visitor Information System the Agency has determined that slightly more than 1,500 exchange visitor programs are currently in operation. The Agency contemplates the continued utilization of existing form IAP-37, "Application for Program Designation" for both initial purposes. Modifications to such form will be made to reflect designation and re-designation proposed changes.

The Agency proposes to prevent this confusion concerning the number of valid exchange programs through a proposed utilization of periodic designations. This action is prompted due to the Agency's recognition that many exchange programs exhibit a life cycle of establishment, maturation and demise. The Agency proposes to designate program sponsors for five years and require sponsors desiring to continue program operations to advise the Agency affirmatively of such intent pursuant to request for redesignation as set forth in § 514.7, *infra*. Such periodic designations will allow the Agency to track program life cycles, efficiently cancel inactive programs, and monitor the activity within and direction of designated exchange programs. Programs for which designation is not sought will be cancelled through administrative action. The Agency contemplates a two-year phase-in of this requirement during which all existing designations will be reviewed and extended, if appropriate.

Program Administration

Agency scrutiny of existing regulations governing the Exchange Visitor Program has revealed a lack of specificity and clarity regarding sponsor obligations and program administration. Although the Agency is secure in its belief that sponsors act in the best interests of sponsored exchange participants, the existing regulations do little to ensure uniform program administration and oversight of

exchange visitors. To correct this deficiency, the Agency proposes amendment to existing regulations in an effort to provide some measure of uniformity in the conduct of exchange activities.

Recognizing that exchange visitors are dependent upon the sponsors who facilitate their entry into the United States, the Agency proposes that such sponsors demonstrate, to Agency satisfaction, their organizational and financial ability to fulfill their duties and obligations as exchange sponsors. Pursuant to proposed regulations set forth at § 514.9, non-government sponsors must affirmatively establish both their ability to pay timely all financial obligations and that sufficient funds are readily available to fulfill all obligations and responsibilities attendant to exchange sponsorship.

The Agency is obligated to introduce this requirement due to evidence of financial instability among certain Agency-designated sponsors. As a matter of administrative convenience, the Agency deems it appropriate to consider public colleges and universities as government sponsors and thereby exempt them from compliance with this provision. In addition to furnishing evidence of fiscal integrity, sponsors must also comply with additional obligations pertaining to internal organizational operations.

The proposed regulation set forth at § 514.9 also requires that sponsors adhere to Agency-promulgated regulations governing the Exchange Visitor Program. This regulation is advanced, in part, to ensure that officers, employees, and agents involved in sponsor facilitation of exchange activities are aware of the Program, its intent and regulatory requirements. This proposed regulation will require employees, officers, and agents responsible for program administration to be adequately trained and qualified to perform assigned duties relating to exchange activities. Underlying this requirement is an Agency concern that responsibility for both exchange visitors and program administration be vested in persons who have knowingly undertaken such responsibility.

Proposed amendments governing the selection and orientation of exchange participants are set forth at § 514.10. The Agency will require that sponsors ensure prospective exchange participants meet the eligibility criteria for program participation and that such program is suitable to the participant's background, needs, and experience. Upon selection for participation and prior to departure from the home country, sponsors will be required to

provide the participant with information regarding the exchange program, travel, housing, and cost. The sponsor must also inform all exchange visitors of the 2-year home residency requirement which may apply to the exchange visitor due to government funding or area of study.

Upon the exchange participant's arrival, or as soon as practical thereafter, the sponsor must provide sufficient orientation to acquaint the exchange visitor with United States customs and monitor the visitor's stay in the United States. This requirement is introduced in an effort to both facilitate the exchange visitor's adjustment to life in the United States and enhance the positive impression of the United States which is the underlying purpose of all exchange activity. Although the Agency has determined that orientation for accompanying dependents is highly desirable, a mandatory requirement that such orientation be conducted is not proposed. The Agency strongly encourages sponsors to provide dependent orientation when the expected stay in the United States will be 1 year or more. It is anticipated that these duties will be performed or directed by the sponsor's designated responsible officer, or alternate responsible officer whose duties are set forth at § 514.11.

A new requirement that sponsors issue a separate IAP-66 form for accompanying dependents is introduced at § 514.12. This requirement will apply to only those individuals seeking dependent status. The Agency is aware that many dependents enter the United States on B visas and that their presence in the United States is unknown to the sponsor. The Agency does not object to this. However, in those exchanges which extend over a number of years, during which dependent spouses are living and working in the United States, such dependents are in effect, participants in the Exchange Visitor Program. Accordingly, an accurate account of such dependents must necessarily be kept. Issuance of a separate IAP-66 for dependent spouses will provide such an account.

A proposed regulation governing certain notification requirements is set forth at § 514.13. Such requirements include notification to the Agency of material changes in a sponsor's organizational structure which affects the citizenship requirement set forth in § 514.2, and overall ownership and control. The Agency is obligated to introduce this requirement as many designated sponsoring organizations are small entities comprised of key personnel. Upon notification of a

substantial change in ownership or control, the Agency will ascertain whether designation should continue based upon the experience and expertise of the new management. It must be noted that Agency designations are not transferable.

Efficient Agency oversight and administration also dictates that sponsors apprise the Agency of any changes in responsible officers, address, or telephone number. In similar fashion, loss of licensure or accreditation, change in financial circumstances or the voluntary termination of the exchange visitor program must be reported. The Agency has also determined that notification concerning a participant's early completion or withdrawal from the sponsor's exchange visitor program is necessary. Upon receipt of such notification the Agency will deem the sponsor's obligations to an exchange visitor to have ended.

Additionally, the Agency has reviewed the health and accident insurance coverage afforded Program participants. The need for such coverage is self-evident. Given the escalating costs of U.S. health care, the current levels of coverage, in place since 1983, are now woefully inadequate. As set forth in § 514.14, the Agency proposes to increase the level of coverage to \$50,000 per accident or illness. A waiting period for pre-existing conditions, reasonable as determined by industry standards, and a deductible not in excess of \$100 per accident or illness will be permitted. Policies may not exclude from coverage perils or dangers inherent to the exchange activity. For example, an insurance policy secured to cover flight training participants may not exclude injury arising from operation of small aircraft. In an effort to ensure the quality of the provided coverage, the Agency proposes that only state-chartered corporations possessing an A. M. Best policyholder rating of "A" or above act as underwriters.

In a departure from current practice, the Agency has determined as a policy matter that all accompanying spouses and dependent children must be covered under an insurance policy. This requirement will extend to all accompanying dependents entering the United States on a J-visa. It is Agency opinion that sponsors may best comply with this provision by arranging for a group policy under which such dependents are covered. The cost of such coverage may be paid by either the sponsor or the exchange participant. The Agency is obligated to introduce this requirement in order to prevent an uninsured spouse and dependent

children from becoming a financial burden upon private institutions, state or local governments who must bear the cost of unreimbursed health care.

Annual Reporting and Control of Form IAP-66

The Agency has determined that a substantial correction must be made to the current practice surrounding the care and custody of the Form IAP-66. Such forms are controlled U.S. Government documents and have been found to have a substantial black market value. The Agency has also discovered unauthorized utilization of the forms by program sponsors to facilitate the entry of foreign nationals for the purpose of participation in non-designated exchange activities. The Agency proposes to correct this abuse by institution of a strict accounting of all forms disbursed to sponsors. To this end, the Agency proposes, pursuant to the provisions of §§ 514.12 and 514.13, that sponsors record and destroy damaged forms, track and record forms issued, and maintain all forms on hand in a secure fashion. An accounting for all forms will be made, in part, pursuant to an expanded annual reporting requirement.

To assist in review of these proposed regulations the Agency attaches as appendices copies of forms which are used in conjunction with sponsor administration of exchange visitor programs. At appendix A is a modified version of the certification used to attest to the citizenship of sponsors and responsible officers. Appendix B contains the IAP-37, the Exchange Visitor Application, which has been approved by the Office of Management and Budget. The Agency anticipates that it will continue to use the form with a few minor changes to reflect § 514.4, Participant Eligibility. However, training program applications require additional information. Consequently, the Agency proposes a new form, Additional Information, Application for Training Program, set forth at Appendix C. Appendix D contains a copy of IAP-87, Update of Information on Exchange Visitor Program Sponsor. The Agency anticipates a limited modification of this form. Finally, at Appendix E, a copy of the proposed annual report form is attached for examination. The Agency concludes that certain privacy issues may arise from requests for information. Such concerns will be addressed by insertion of a general waiver on the IAP-66 form similar to that now found on the Immigration and Naturalization Service form I-20.

Public Comment

The Agency is inviting comments from the public on the proposed regulations notwithstanding that it is under no legal requirement to do so. The designation of exchange visitor sponsors and administration of the Exchange Visitor Program are a foreign affairs function. The Administrative Procedure Act, 5 U.S.C. 553(a)(1) (1989), specifically exempts from application of the Act a "foreign affairs function of the United States."

In the interest of preserving its valuable working relationship with the exchange community, the Agency is providing a ninety-day period for written comments on the proposed regulations. In order to expedite review of the comments the Agency requests that interested parties submit five copies of their comments.

The Agency informally circulated a prior draft of the proposed regulations to some members of the exchange community. The Agency received informal comments in response. The Agency reviewed those comments and incorporated some of the suggestions into these proposed regulations. If these parties wish further consideration of their position, or wish to influence the outcome of the final rule, they must submit written comments to the Agency in response to this proposal.

In addition, the Agency intends to schedule one or more public meetings during the comment period in order to receive the views of interested parties. The time, date, and place of such meetings will be published in the *Federal Register*. Such actions may not be deemed a waiver of the foreign affairs exemption extended the Agency pursuant to the terms of the Administrative Procedure Act.

List of Subjects in 22 CFR Part 514

Cultural exchange programs.

Date: November 15, 1991.

Alberto J. Mora,
General Counsel.

Accordingly, the Agency proposes to revise 22 CFR part 514 to read as follows:

PART 514—EXCHANGE VISITOR PROGRAM

Subpart A—General Provisions

- Sec.
- 514.1 Purpose.
- 514.2 Definitions.
- 514.3 Sponsor eligibility.
- 514.4 Participant eligibility.
- 514.5 Application procedure.
- 514.6 Designation.
- 514.7 Redesignation.

- Sec.
- 514.8 General program requirements.
- 514.9 General obligations of sponsors.
- 514.10 Program administration.
- 514.11 Duties of responsible officers.
- 514.12 Control of forms IAP-66.
- 514.13 Notification requirements.
- 514.14 Insurance.
- 514.15 Annual reports.
- 514.16 Fees and charges [Reserved]

Subpart B—Specific Program Provisions

- 514.20 Professors and researchers [Reserved]
- 514.21 Scholars [Reserved]
- 514.22 Trainees [Reserved]
- 514.23 College and university students [Reserved]
- 514.24 Teachers [Reserved]
- 514.25 Secondary school students [Reserved]
- 514.26 Specialists [Reserved]
- 514.27 Biomedical researchers [Reserved]
- 514.28 Physicians [Reserved]
- 514.29 International visitors [Reserved]
- 514.30 Government visitors [Reserved]
- 514.31 Camp counselors [Reserved]

Subpart C—Status of Exchange Visitors.

- 514.40 Termination of exchange visitor status.
- 514.41 Change of category [Reserved]
- 514.42 Transfer of program [Reserved]
- 514.43 Extension of stay [Reserved]
- 514.44 Two-year foreign residence requirement [Reserved]

Subpart D—Sanctions

- 514.50 Sanctions [Reserved]

Subpart E—Termination and Revocation of Programs

- 514.60 Termination of designation.
- 514.61 Revocation.
- 514.62 Responsibilities of the sponsor upon termination or revocation.

Appendix A to Part 514—Certification of Officers and Sponsors

Authority: 8 U.S.C. 1101(a)(15)(J), 1182, 1258; 22 U.S.C. 1431-1442, 2451-2460; Reorg. Plan No. 2 of 1977; E.O. 12048 of March 27, 1978; USIA Delegation Order No. 85-5 (50 FR 27393).

Subpart A—General Provisions

§ 514.1 Purpose.

(a) The regulations set forth in this Part implement the Mutual Educational and Cultural Exchange Act of 1961 (the "Act"). 22 U.S.C. 2451 (1988). The purpose of the Act is to increase mutual understanding between the people of the United States and the people of other countries by means of educational and cultural exchanges. Educational and cultural exchanges are defined by section 102 of the Act and are limited to the activities described therein.

(b) The Director of the United States Information Agency facilitates activities specified in the Act, in part, by designating public and private entities to

act as sponsors of the Exchange Visitor Program. The purpose of the Program is to provide foreign nationals with opportunities to participate in educational and cultural programs in the United States and return home to share their experiences, and for Americans to participate in educational and cultural programs in other countries. Educational and cultural exchanges assist the Agency in furthering the foreign policy objectives of the United States. Exchange visitors enter the United States on a J-visa. The regulations set forth in this subpart are applicable to all sponsors.

§ 514.2 Definitions.

Accredited educational institution means any publicly or privately operated primary, secondary, or post-secondary institution of learning duly recognized and declared as such by the appropriate accrediting authority of the state in which such institution is located; provided, however, that in addition to any state accreditation, all post-secondary institutions shall also be accredited by a nationally recognized accrediting agency or association as designated by the United States Secretary of Education. Post-secondary institutions shall include "Community College," "College," "University," "Seminary," "Conservatory," "School," "Institute," and "Academy," but shall not include any institution whose offered programs are primarily vocational in nature.

Act means the Mutual Educational and Cultural Exchange Act of 1961, as amended.

Agency means the United States Information Agency.

Citizen of the United States means:

(1) An individual who is a citizen or permanent resident of the United States or one of its territories or possessions; or,

(2) A general or limited partnership created or organized under the laws of the United States, or of any State, the District of Columbia, or a territory or possession of the United States, of which a majority of the partners are citizens of the United States; or,

(3) A for-profit corporation, association, or other legal entity created or organized under the laws of the United States, or of any state, the District of Columbia, or a territory or possession of the United States, which:

(i) Has its principal place of business in the United States, and

(ii) Has its shares or voting interests publicly traded on a U.S. stock exchange; or, if its shares or voting interests are not publicly traded on a U.S. stock exchange, it shall

nevertheless be deemed to be a citizen of the United States if a majority of its officers, Board of Directors, and its shareholders are citizens of the United States; or,

(4) A non-profit corporation, association, or other legal entity created or organized under the laws of the United States, or any state, the District of Columbia, or territory or possession of the United States, and,

(i) Which is qualified with the Internal Revenue Service as a tax-exempt organization pursuant to section 501(c) of the Internal Revenue Code; and

(ii) Which has its principal place of business in the United States; and,

(iii) In which a majority of its officers and a majority of its Board of Directors or other like body vested with its management are citizens of the United States; or,

(5) An accredited college, university, or other institution of higher education created or organized under the laws of the United States, or of any State, including a county, municipality, or other political subdivision thereof, the District of Columbia, or of a territory or possession of the United States; or,

(6) An agency of the United States, or of any State or local government, the District of Columbia, or a territory or possession of the United States.

Consortium means a not-for-profit corporation, association, or other legal entity formed by two or more accredited educational institutions for the purpose of sharing educational resources, conducting research, and/or developing new programs to enrich or expand the opportunities offered by its members.

Cross-cultural activities means activities which are designed to promote exposure and interchange between exchange visitors and Americans so as to increase their understanding of each other's peoples, culture, and institutions. Examples of such activities may include a reception with colleagues, picnics, visits to state capitols, international festivals, sporting events, rodeos, visits to farms, cultural events, and social events in the local communities.

Designation means the written authorization supplied by the Agency to an exchange visitor program applicant to conduct an exchange visitor program as a sponsor.

Director means either the Director of the United States Information Agency or an employee of the Agency acting under a delegation of authority from the Director.

Exchange visitor means any foreign national who has been selected by a sponsor to participate in an exchange visitor program and who is seeking to enter or has entered the United States

temporarily on a J-1 visa, or who is seeking to acquire or has acquired such status after admission.

Exchange Visitor Program means the international exchange program administered by the Agency to implement the Act by means of educational and cultural programs. When "exchange visitor program" is set forth in lower case, it refers to the individual program of a sponsor which has been designated by the Agency.

Exchange Visitor Program Services means the Agency staff delegated by the Director to administer those provisions of the Exchange Visitor Program set forth in this Part.

Exchange visitor's government means the government of the country of the exchange visitor's nationality or where the exchange visitor has a legal permanent residence to which he or she is entitled to return.

Financed directly means financed in whole or in part by the United States Government or the exchange visitor's government with funds contributed directly to the exchange visitor in connection with his or her participation in an exchange visitor program.

Financed indirectly means:

(1) Financed by an international organization, with funds contributed by either the United States or the exchange visitor's government for use in financing international educational and cultural exchanges, or

(2) Financed by an organization or institution with funds made available by either the United States or the exchange visitor's government for the purpose of furthering international educational and cultural exchange.

Form IAP-66 means a Certificate of Eligibility, a controlled document of the Agency.

Full course of study means enrollment in an academic program of classroom participation and study at an accredited educational institution resulting in the award of not less than 12 semester hours or equivalent of academic credit per academic term, provided however:

(1) Secondary school students shall satisfy the attendance and course requirements of the state of temporary residence; and

(2) Post-baccalaureate students studying in the United States shall satisfy the requirements of this Part by successful completion of not less than nine hours or equivalent of academic credit per academic term unless engaged in the sanctioned research and drafting of a thesis necessary for award of degree.

Immediate family means the alien spouse and minor unmarried children of

an exchange visitor who are accompanying or following to join the exchange visitor and who are seeking to enter or have entered the United States temporarily on a J-2 visa or are seeking to acquire or have acquired such status after admission.

J-visa means a non-immigrant visa issued pursuant to 8 U.S.C.

1101(a)(15)(J). A J-1 visa is issued to the exchange visitor. J-2 visas are issued to the exchange visitor's immediate family.

Reciprocity means the participation of a United States citizen in an educational and cultural program in a foreign country in exchange for the participation of a foreign national in the Exchange Visitor Program. Where used herein, "reciprocity" shall be interpreted broadly; reciprocity does not require a one-for-one exchange nor that exchange visitors be engaged in the same activity. For example, foreign trainees coming to the United States for training in American banking practices and Americans going abroad to train foreign nationals in public administration would be considered a reciprocal exchange, when arranged or facilitated by the same sponsor.

Responsible officer means the employee or officer of a designated sponsor who has been listed with the Agency as assuming the responsibilities outlined in § 514.11. The designation of alternate responsible officers is permitted and encouraged. The responsible officer and any alternate responsible officer must be a United States citizen or a person who has been lawfully admitted to the United States for permanent residence.

Sponsor means:

(1) Any United States federal, state, or local government agency;

(2) An international agency or organization of which the United States is a member and has offices in the United States; or,

(3) A reputable organization which is a "citizen of the United States," as that term is defined in this regulation; and,

(4) Which makes an application as prescribed to the Director of the United States Information Agency for designation of a program under its sponsorship as an exchange visitor program and whose application is approved.

Third party means an individual or non-designated entity upon whom the sponsor relies, in whole or in part, to carry out its Exchange Visitor Program obligations and responsibilities.

§ 514.3 Sponsor eligibility.

Any local, state, or federal government agency or any other legal entity which is a citizen of the United

States, as defined by these regulations at § 514.2, is eligible to apply for designation as a sponsor of an exchange visitor program if it is able to:

(a) Demonstrate, to the Agency's satisfaction, the ability to comply and remain in continual compliance with all provisions of Part 514; and

(b) Meet at all times its financial obligations and responsibilities attendant to successful sponsorship of its exchange visitor program.

§ 514.4 Participant eligibility.

Sponsors may select foreign nationals to participate in their exchange visitor programs. Participation by foreign nationals in an exchange visitor program is limited to individuals who shall be engaged in the following activities in the United States:

(a) *Student*. An individual who is:

(1) Pursuing a recognized full course of study leading to or culminating in the award of either a diploma or degree from an accredited educational institution; or

(2) Engaged in full-time participation in a prescribed course of study of less than one year in duration sponsored and conducted by an accredited educational institution.

(b) *Scholar*. An influential or distinguished person coming to the United States on a short-term visit for the purpose of observation, consultation, or demonstration of special skills at a research institution, museum, library, accredited institution of higher education, or similar type of institution.

(c) *Trainee*. An individual participating in a structured training program conducted by the selecting sponsor.

(d) *Teacher*. An individual teaching full-time in an accredited primary or secondary school.

(e) *Professor*. An individual primarily teaching, lecturing, observing, or consulting at an accredited institution of higher education, museum, library, or similar type of institution. A professor may also conduct research with permission of the responsible officer. The term "professor" does not include a student who has a graduate or teaching assistantship.

(f) *Researcher*. An individual primarily conducting research, observing, or consulting in connection with a research project at a research institution, museum, library, accredited institution of higher education, or similar type of institution. The researcher may also teach or lecture with permission of the responsible officer. The term "researcher" does not include a student who has a graduate research assistantship or a laboratory technician.

(g) *Specialist*. An individual of distinguished merit and ability coming to the United States for the purpose of observation and consultation at a senior organizational level.

(h) *Other Person of Similar Description*. An individual of description similar to those set forth in paragraphs (a) through (g) coming to the United States for the purpose of teaching, instructing or lecturing, studying, observing, conducting research, consulting, demonstrating special skills, or receiving training. Programs designated by the Agency in this category include, but are not limited to:

(1) *International Visitor*. An individual selected by the Agency who is a recognized leader or potential leader, expert in a field of specialized knowledge or skill, or who is recognized as an influential or distinguished person for the purpose of observation, consultation, research, training, or demonstration of special skills.

(2) *Government Visitor*. An individual selected by a United States local, state, or federal government agency who is a recognized leader or potential leader, expert in a field of specialized knowledge or skill, or who is recognized as an influential or distinguished person for the purpose of observation, consultation, research, training, or demonstration of special skills.

(3) *Camp Counselor*. An individual selected to be a counselor in a summer camp in the United States who imparts skills to American campers and teaches them about his or her country.

§ 514.5 Application procedure.

(a) Any entity meeting the eligibility requirements set forth in § 514.3 may apply to the Agency for designation as a sponsor. Such application shall be made on Form IAP-37 ("Exchange Visitor Program Application") and filed with the Agency's Exchange Visitor Program Services.

(b) The application shall set forth, in detail, the applicant's proposed exchange program activity and shall demonstrate its prospective ability to comply with Exchange Visitor Program regulations.

(c) The applicant must provide:

(1) Evidence of legal status as a corporation, partnership, or other legal entity (e.g., charter, proof of incorporation, partnership agreement, as applicable) and current certificate of good standing;

(2) Evidence of financial responsibility as set forth at § 514.9(e);

(3) Evidence of accreditation if the applicant is an educational institution;

(4) Evidence of licensure, if required by local, state, or federal law, to carry out the activity for which it is to be designated;

(5) A resolution or directive by the applicant's governing body authorizing the application for sponsor designation; and

(6) Certification by the applicant that it and its responsible officer and alternate responsible officers are citizens of the United States as defined at § 514.2 using the language set forth in appendix A.

(d) The Agency may request any additional information or documentation which it deems necessary to evaluate the application.

§ 514.6 Designation.

(a) Upon a favorable determination that the proposed exchange program meets all statutory and regulatory requirements, the Agency may, in its sole discretion, designate an entity meeting the eligibility requirements set forth in § 514.3 as an exchange visitor program sponsor.

(b) Designation shall confer upon the sponsor authority to engage in one or more activities specified in § 514.4. A sponsor shall not engage in activities not specifically authorized in its written designation.

(c) Designations are effective for a period of five years. In its discretion, the Agency may designate programs, including pilot or experimental programs, for less than five years.

§ 514.7 Redesignation.

(a) Upon expiration of a given designation term, sponsors may seek redesignation for another five year term.

(b) Applications for redesignation shall be accompanied by the documentation specified at § 514.5(c) and such additional documentation as the Agency may request.

(c) Applications for redesignation shall be evaluated according to the criteria set forth at § 514.6(a) taking into account the applicant's prior record as an exchange visitor program sponsor.

(d) In order to avoid discontinuity in its exchange visitor program, a sponsor seeking redesignation should apply to the Agency no less than six months prior to the expiration date of its designation.

§ 514.8 General program requirements.

(a) *Reciprocity.* (1) In the conduct of their exchange programs, sponsors shall ensure the fullest possible reciprocity.

(2) In those situations where the opportunity for reciprocity is limited or not possible, the sponsor must present evidence satisfactory to the Agency as

to why no, or only limited, reciprocity is possible. In cases where only limited reciprocity is possible, the Agency after consultation with the sponsor, will establish reasonable reciprocity goals. In cases where no reciprocity is possible, the Agency, in its discretion, may waive this requirement upon a determination by the Agency that the proposed program will nevertheless further the purpose of the Act.

(b) *Cross-cultural Activities.* Sponsors shall provide, throughout their exchange visitor programs, a reasonable amount of cross-cultural activity both on and away from the site where the exchange activities are centered. Reasonableness shall be determined by the needs and interests of the particular category of exchange visitors.

(c) *Size of Program.* (1) Sponsors, other than federal government agencies, shall have no less than five exchange visitors per calendar year.

(2) In response to a sponsor's request, the Agency shall determine, in its discretion, the number of Forms IAP-66 to be issued to each sponsor each calendar year. If additional forms are needed, the sponsor may submit an additional request to the Agency.

(d) *Minimum Duration of Program.* Sponsors, other than federal government agencies, shall provide each exchange visitor, except scholars and government visitors, with a minimum length of stay in the United States of three weeks.

§ 514.9 General obligations of sponsors.

(a) *Adherence to Agency Regulations.* Sponsors are required to adhere to all regulations set forth in part 514.

(b) *Legal Status.* Sponsors shall maintain legal status. A change in a sponsor's legal status (e.g. partnership to corporation) shall require application for designation of the new legal entity. Designation is not transferable or assignable.

(c) *Accreditation and Licensure.* Sponsors shall remain in compliance with all local, state, federal, and professional requirements necessary to carry out the activity for which they are designated, including accreditation and licensure, if applicable.

(d) *Representations and Disclosures.* Sponsors shall provide accurate and complete information concerning their exchange visitor programs to the Agency, exchange visitors, and the public. Sponsors shall:

(1) Provide literature to prospective exchange visitors which clearly explains the activities, costs, conditions, and restrictions of the program;

(2) Except for United States Government sponsors, not represent that the program is endorsed, sponsored,

or supported by the Agency or the United States Government; and

(3) Not use, print, or divulge the program designation number except on completed Forms IAP-66 and in communications with the Agency or other interested Federal, state, and local government agencies.

(e) *Financial Responsibility.* (1) Sponsors shall maintain the financial capability to meet at all times their financial obligations and responsibilities attendant to successful sponsorship of their exchange visitor programs.

(2) The Agency may require non-government sponsors to provide evidence satisfactory to the Agency that funds necessary to fulfill all obligations and responsibilities attendant to sponsorship of exchange visitors are readily available and in the sponsor's control, including such supplementary or explanatory financial information as the Agency may deem appropriate.

(3) The Agency may, in its sole discretion, require any non-government sponsor to secure a payment bond in favor of the Agency guaranteeing all financial obligations arising from the sponsorship of exchange visitors.

(f) *Staffing.* Sponsors shall ensure adequate staffing in the administration of their exchange visitor programs. Sponsors shall ensure that their employees, officers, and agents and third parties involved in the administration of their exchange visitor programs are adequately qualified and trained and comply with the Exchange Visitor Program regulations.

(g) *Appointment of Responsible Officer.* (1) The sponsor shall appoint a responsible officer and such alternate responsible officers as may be necessary to perform the duties set forth at § 514.11.

(2) The responsible officer and alternate responsible officers shall be employees or officers of the sponsor. The Agency may, however, in its discretion, authorize the appointment of an agent of the sponsor who is not an employee or officer to serve as an alternate responsible officer.

(3) The Agency may, in its discretion, direct the replacement of the responsible officer or any alternate responsible officers when such officers demonstrate a disregard for Agency regulations.

(4) The Agency may, in its discretion, limit the number of alternate responsible officers appointed by the sponsor.

§ 514.10 Program administration.

Sponsors are responsible for the effective administration of their

exchange visitor programs. These responsibilities include:

(a) *Selection of Exchange Visitors.*

Sponsors shall screen and select prospective exchange visitors to ensure that they are eligible for program participation, and that the program is suitable to the exchange visitor's background, needs, and experience.

(b) *Pre-arrival Information.* Sponsors shall provide exchange visitors with pre-arrival materials including, but not limited to, information on:

- (1) The purpose of the Exchange Visitor Program;
- (2) The two-year foreign residence requirement;
- (3) Travel and entry into the United States;
- (4) Housing;
- (5) Fees payable to the sponsor and other costs that the exchange visitor will likely incur while in the United States;
- (6) Health care and insurance; and
- (7) Other information which will assist exchange visitors to prepare for their stay in the United States.

(c) *Orientation.* Sponsors shall provide orientation for all exchange visitors. Sponsors are encouraged to provide orientation for the immediate family members of exchange visitors, especially those who are expected to be in the United States for more than one year. Orientation shall include, but not be limited to, providing information concerning:

- (1) Life and customs in the United States and the local community;
- (2) Local community resources (e.g. public transportation, schools, libraries, recreation centers, and banks);
- (3) A description of the program in which the exchange visitor is participating;
- (4) Rules that the exchange visitor and his or her family are required to follow;
- (5) Address of the sponsor and the name and telephone number of the responsible officer; and
- (6) Address and telephone number of the Exchange Visitor Program Services of the Agency and a copy of the Exchange Visitor Program brochure outlining the regulations relevant to the exchange visitors.

(d) *Form IAP-66 and Communications.* Sponsors shall ensure that only the responsible officer or alternate responsible officers issue Forms IAP-66. The Agency prefers official communications be channeled through the responsible officer.

(e) *Monitoring of Exchange Visitors.* Sponsors shall monitor the exchange visitors participating in their programs. Sponsors shall:

- (1) Ensure that the activity in which the exchange visitor is engaged is

consistent with the category and activity listed on the exchange visitor's Form IAP-66;

(2) Monitor the progress and welfare of the exchange visitor; and

(3) Require the exchange visitor to keep the sponsor apprised of his or her address and telephone number, and maintain such information.

(f) *Requests by the Agency.* Sponsors shall furnish to the Agency all information, reports, documents, books, files, and other records requested by the Agency on all matters related to the sponsor's exchange visitor programs.

(g) *Inquiries and Investigations.* Sponsors shall cooperate to the fullest extent with any inquiry or investigation that may be undertaken by the Agency.

(h) *Retention of Records.* Sponsors shall retain all records related to their exchange visitor program for three years.

§ 514.11 Duties of responsible officers.

Responsible officers shall train and supervise alternate responsible officers. Responsible officers and alternate responsible officers shall:

(a) *Advisement and Assistance.* Ensure that the exchange visitor obtains sufficient advice and assistance to facilitate the successful completion of the exchange visitor's program.

(b) *Communications.* Conduct all communications relating to the exchange visitor program with the Agency, the United States Immigration and Naturalization Service, or United States Department of State. Reference to the sponsor's program number shall be made on any correspondence with the Agency.

(c) *Custody of the Form IAP-66.* Act as custodian for the control, issuance, and disbursement of Form IAP-66 as set forth in § 514.12.

(d) *Agency's Codebook and Instructions.* Comply with the Agency's current *Codebook and Instructions for Responsible Officers*.

§ 514.12 Control of Forms IAP-66.

Forms IAP-66 shall be used only for authorized purposes. To maintain adequate control of Forms IAP-66, responsible officers or alternate responsible officers shall:

(a) *Requests.* Submit written requests to the Agency for a one year supply of Form IAP-66.

(b) *Verification.* Prior to issuing Form IAP-66, verify that the exchange visitor:

- (1) Is eligible, qualified, and accepted for the program in which he or she will be participating;

- (2) Possesses adequate financial resources to complete his or her program; and

(3) Possesses adequate financial resources to support any accompanying dependents.

(c) *Issuance of Form IAP-66.* Issue the Form IAP-66 only so as to:

(1) Facilitate the entry of a new participant of the Exchange Visitor Program;

(2) Extend the stay of an exchange visitor;

(3) Facilitate program transfer;

(4) Replace a lost or stolen Form IAP-66;

(5) Facilitate entry of an exchange visitor's alien spouse or minor unmarried children into the United States; or

(6) Report a change of funding when a non-government sponsored exchange visitor begins to receive direct or indirect financing as defined in § 514.2;

(7) Facilitate re-entry of an exchange visitor who has traveled outside the United States during the program; or

(8) Facilitate a change of category when permitted by the Agency.

(d) *Safeguards.* (1) Store Forms IAP-66 securely to prevent unauthorized use;

(2) Prohibit transfer of any blank Form IAP-66 to another sponsor or other person unless authorized in writing (by letter or facsimile) by the Agency to do so;

(3) Notify the Agency promptly by telephone (confirmed promptly in writing) or facsimile of the document number of any completed or blank Form IAP-66 that is lost or stolen;

(4) Not send a prospective exchange visitor a Form IAP-66 if a Form I-20 has been sent by the sponsor, unless the Form I-20 has been returned or reported lost; and

(5) Forward the completed Form IAP-66 only to an exchange visitor, either directly or via an employee, officer, or agent of the sponsor.

(e) *Accounting.* (1) Maintain a record of all Forms IAP-66 received by the sponsor;

(2) Destroy damaged and unusable Forms IAP-66 on the sponsor's premises after making a record of such forms (e.g. forms with errors or forms damaged by a printer); and

(3) Request exchange visitors and prospective exchange visitors return any unused Form IAP-66 sent to them and:

(i) make a record of Forms IAP-66 which are returned to the sponsor and destroy them on the sponsor's premises; and

(ii) make a record of Forms IAP-66 not returned to the sponsor within 90 days of the expected program commencement date.

§ 514.13 Notification requirements.

(a) *Change of Circumstances.* Sponsors shall notify the Agency promptly in writing of any of the following circumstances:

(1) Change of address, telephone, or facsimile number;

(2) Change in the composition of the sponsoring organization such that it affects its citizenship as defined by § 514.2;

(3) Change of the responsible officer or alternate responsible officers;

(4) A major change of ownership or control of the sponsor's organization;

(5) Change in financial circumstances such that the sponsor may be unable to comply with its obligations as set forth in 514.9(e);

(6) Loss of licensure or accreditation;

(7) Loss or theft of Forms IAP-66 as specified at § 514.12(d)(3); or

(8) Termination of its exchange visitor program.

(b) *Crisis or Emergency.* Sponsors shall inform the Agency promptly by telephone or facsimile of any crisis or serious emergency involving the health of an exchange visitor or which may have an adverse impact on the diplomatic relations of the United States Government.

(c) *Status of Exchange Visitor.*

(1) Sponsors shall notify the Agency and the Immigration and Naturalization Service in writing when:

(i) the exchange visitor has completed or withdrawn from a program prior to the ending date on his or her Form IAP-66;

(ii) the exchange visitor ceases to maintain exchange visitor status; or

(iii) an exchange visitor's participation in the Exchange Visitor Program is terminated in accordance with § 514.40.

(2) Such notification shall include:

(i) the reason for notification;

(ii) admission number on the exchange visitor's Form I-94; and

(iii) a copy of the exchange visitor's most recent Form IAP-66.

§ 514.14 Insurance.

(a) Sponsors shall ensure that an insurance policy is continuously in effect which covers each exchange participant and any accompanying dependents on a J-visa for illness, health, and accidents for the period of time that the visitors are present in the United States. Minimum levels of coverage shall provide:

(1) Medical benefits of \$50,000 per accident or illness; and

(2) Repatriation of remains in the amount of \$7,500;

(3) Expenses associated with the medical evacuation of the exchange

visitor to his or her home country in the amount of \$10,000.

(b) Any insurance policy secured to fulfill the requirements of this section shall be underwritten by a United States state-chartered corporation having an A.M. Best policyholder rating of "A" or above. Such policies:

(1) May require a waiting period for pre-existing conditions which is reasonable as determined by current industry standards;

(2) May include a deductible not in excess of \$100 per insured period; and

(3) Shall not exclude coverage for perils inherent to the activities of the exchange program.

§ 514.15 Annual reports.

Sponsors shall submit an annual report to the Agency. Such report shall be filed on an academic or calendar year basis, as directed by the Agency, and shall contain the following:

(a) *Program Report and Evaluation.* A brief summary of the activities in which exchange visitors were engaged, including an evaluation of program effectiveness;

(b) *Reciprocity.* A description of the nature and extent of reciprocity occurring in the sponsor's exchange visitor program during the reporting year;

(c) *Cross-cultural Activities.* A summary of the cross-cultural activities provided for its exchange visitors during the reporting year;

(d) *Proof of Insurance.* Certification of insurance coverage for all exchange visitors as required by § 514.14.

(e) *Form IAP-66 Usage.* A report of Form IAP-66 usage during the reporting year setting forth the following information:

(1) The total number of blank Forms IAP-66 received from the Agency during the reporting year;

(2) The total number of Forms IAP-66 voided or destroyed by the sponsor during the reporting year and the document numbers of such forms;

(3) The total number of Forms IAP-66 issued to potential exchange visitors that were returned to the sponsor or not used for entry into the United States; and

(4) The total number and document identification number sequence of all blank Forms IAP-66 in the possession of the sponsor on December 31 of the reporting year.

(f) *Program Transfers.* A list of program transfers granted to exchange visitors, set forth by Form IAP-66 document number, name, category of participation, home country, date through which the exchange visitor's

stay is extended, and the reason for transfer;

(g) *Change of Visa Status.* A list, set forth by Form IAP-66 document number, name, category of participation, home country, and date, detailing:

(1) Aliens who acquired J-visa status by transfer from another visa category and the type of visa from which they transferred;

(2) Exchange visitors who transferred to another visa and the type of visa to which they transferred; and,

(3) Exchange visitors who applied for permanent residence;

(h) *Program Terminations.* A list of exchange visitors whose program was prematurely terminated prior to the date indicated on the Form IAP-66 during the year set forth by name, and Form IAP-66 document number, and the reason for termination;

§ 514.16 Fees and charges. [Reserved]**Subpart B—Specific Program Provisions**

Sec.

514.20 Professors and Researchers [Reserved]

514.21 Scholars [Reserved]

514.22 Trainees [Reserved]

514.23 College and University Students [Reserved]

514.24 Teachers [Reserved]

514.25 Secondary School Students [Reserved]

514.26 Specialists [Reserved]

514.27 Biomedical Researchers [Reserved]

514.28 Physicians [Reserved]

514.29 International Visitors [Reserved]

514.30 Government Visitors [Reserved]

514.31 Camp Counselors [Reserved]

Subpart C—Status of Exchange Visitors**§ 514.40 Termination of Exchange Visitor Status.**

A sponsor shall terminate an exchange visitor's participation in its program when the exchange visitor:

(a) Fails to pursue the activities for which he or she was admitted to the United States;

(b) Is unable to continue; or

(c) Violates of the rules and regulations governing the sponsor's program sufficient to warrant termination.

Sec.

514.41 Change of category. [Reserved]

514.42 Transfer of program. [Reserved]

514.43 Extension of stay. [Reserved]

514.44 Two-year foreign residence requirement. [Reserved]

Subpart D—Sanctions**§ 514.50 Sanctions [Reserved]****Subpart E—Termination and Revocation of Programs****§ 514.60 Termination of designation.**

Designation shall be terminated when any of the circumstances set forth in this section occur.

(a) *Voluntary Termination.* A sponsor may voluntarily terminate its designation by notifying the Agency of such intent. The sponsor's designation shall terminate upon such notification. Such sponsor may reapply for designation.

(b) *Inactivity.* A sponsor's designation shall automatically terminate for inactivity if the sponsor fails to comply with the minimum size or duration requirements, as specified in § 514.8 (c) and (d), in any twelve month period. Such sponsor may reapply for program designation.

(c) *Failure to File Annual Reports.* A sponsor's designation shall automatically terminate if the sponsor fails to file annual reports for two consecutive years. Such sponsor is eligible to reapply for program designation upon the filing of the past due annual reports.

(d) *Change in Ownership or Control.* An exchange visitor program designation is not assignable or transferable. A major change in ownership or control automatically terminates the designation. However, the successor sponsor may apply to the Agency for redesignation and may continue its exchange visitor activities while approval of the application for redesignation is pending before the Agency.

(1) With respect to a for-profit corporation, a major change in ownership shall be deemed to have occurred when thirty-three and one-third percent (33 1/3 percent) or more of its stock is sold or otherwise transferred;

(2) With respect to a not-for-profit corporation, a major change of control shall be deemed to have occurred when fifty percent or more of the board of trustees, or other like body vested with its management, is replaced.

(e) *Loss of Licensure or Accreditation.* A sponsor's designation shall

automatically terminate in the event that the sponsor fails to remain in compliance with local, state, federal, or professional requirements necessary to carry out the activity for which it is designated, including loss of accreditation or licensure.

(f) *Failure to Apply for Redesignation.* Prior to the conclusion of its current designation period, the sponsor is required to apply for redesignation pursuant to the terms and conditions of § 514.7. Failure to apply for redesignation will result in the automatic termination of the sponsor's designation. If so terminated, the former sponsor may apply for a new designation, but the program activity will be suspended during the pendency of the application.

§ 514.61 Revocation.

A designation may be terminated by revocation for cause as specified in § 514.40. A sponsor whose designation has been revoked may not apply for a new designation.

§ 514.62 Responsibilities of the sponsor upon termination or revocation.

Upon termination or revocation of its designation, the sponsor shall:

(a) Fulfill its responsibilities to all exchange visitors who are in the United States at the time of the termination or revocation;

(b) Notify exchange visitors who have not entered the United States that the program has been terminated unless a transfer to another designated program can be obtained; and

(c) Return all Forms IAP-66 in the sponsor's possession to the Agency within 30 days of program termination or revocation.

Appendix A to Part 514—Certification of Responsible Officers and Sponsors

In accordance with the requirement at § 514.5(c)(5), the text of the certifications shall read as follows:

1. Responsible Officers and Alternate Responsible Officers.

I hereby certify that I am the responsible officer (or alternate responsible officer, specify) for exchange visitor program number _____, and that I am a United States citizen or permanent resident. I understand that the United States Information Agency may request supporting documentation as to my citizenship or permanent residence at any

time and that I must supply such documentation when and as requested. (Name of organization) agrees that my inability to substantiate the representation of citizenship or permanent residence made in this certification will result in the immediate withdrawal of its designation and the immediate return of or accounting for all Forms IAP-66 transferred to it.

Signed in ink by

(Name)

(Title)

Witness:

This _____ day of _____, 19____.
Subscribed and sworn to before me this
_____ day of _____, 19____.

Notary Public

2. Sponsors.

I hereby certify that I am an officer of (Name of Organization) with the title of (specify); that I am authorized by the (Board of Directors, Trustees, etc.) to sign this certification and bind (Name of Organization); and that a true copy certified by (Board of Directors, Trustees, etc.) of such authorization is attached. I further certify that (Name of Organization) is a citizen of the United States as that term is defined at 22 CFR 514.2. (Name of Organization) agrees that inability to substantiate the representation of citizenship made in this certification will result in the immediate withdrawal of its designation and the immediate return of or accounting for all Forms IAP-66 transferred to it.

Signed in ink by

(Name)

(Title)

Attestation/Witness:

This _____ day of _____, 19____.
Subscribed and sworn to before me this
_____ day of _____, 19____.

Notary Public

Appendix B—Form IAP-37 Exchange Visitor Program Application

Note: This appendix will not appear in the Code of Federal Regulations.

BILLING CODE 8230-01-M

United States Information Agency GENERAL COUNSEL, EXCHANGE VISITOR FACILITATIVE STAFF EXCHANGE-VISITOR PROGRAM APPLICATION						FORM APPROVED O.M.B. NO. 3116-0009 (11/82) *Estimated Burden Hours 1 hour SERIAL NO. (Not to be filled in by applicant)		
NAME AND ADDRESS OF SPONSORING ORGANIZATION								
NAME AND TITLE OF RESPONSIBLE OFFICER				Telephone Number		APPLICATION (Check one) ☐ NEW ☐ AMENDMENT		
NAME AND TITLE OF ALTERNATE RESPONSIBLE OFFICER				Telephone Number				
SECTION I - PROGRAM PARTICIPANT DATA								
1. PARTICIPATION BY CATEGORY (Indicate total no. and approximate duration of stay in each category or categories)								
TYPE	NUMBER	DURATION	TYPE	NUMBER	DURATION	TYPE	NUMBER	DURATION
A. STUDENT			C. TEACHER			E. 1. SPECIALIST		
B. BUS./IND. AND OTHER TRAINEES			D. PROFESSOR			F. INT'L VISITOR		
			E. RESEARCH SCHOLAR			G. PROFESSIONAL TRAINEE		
(See reverse side for definitions of types of participants and general limitations of stay (22 CFR 514.2 and 514.23).)								
2. METHOD OF SELECTION								
3. ARRANGEMENTS FOR FINANCIAL SUPPORT OF EXCHANGE VISITOR WHILE IN THE UNITED STATES (Specify source and amount of funding)								
SECTION II - PROGRAM DATA								
4. OUTLINE OF PROPOSED ACTIVITIES								
5. ARRANGEMENTS FOR SUPERVISION AND DIRECTION								
6. PURPOSE OR OBJECTIVE								
7. ROLE OF OTHER ORGANIZATIONS ASSOCIATED WITH PROGRAM (If any)								
SECTION III - CERTIFICATION								
I certify that information given in this application is true to the best of my knowledge and belief.								
DATE		SIGNATURE OF RESPONSIBLE OFFICER						

IAP-37 (4-90)

(SEE REVERSE SIDE FOR INSTRUCTIONS)

BILLING CODE 8230-01-C

Instructions

If additional space is needed in supplying answers to any questions, please use continuation sheets on plain white paper.

In connection with study, training, or research involved in the program, submit information or evidence with respect to the approval, recognition, or accreditation of the agency or institution, copies of annual reports, institutional catalogs, and the like, that may be required in establishing the eligibility of the program for designation.

Mail this application to the General Counsel, Exchange Visitor Facilitative Staff, United States Information Agency, Washington, DC 20547. At least 45 days should be allowed for review of application.

N.B. The attention of all applicants is specifically directed to sections 514.11, 514.12, 514.13, and 514.14 of the Exchange Visitor regulations (22 CFR 514) which outline the responsibilities assumed by sponsors of designated programs.

514.2 Types of participants.

Participants include, but are not limited to, the following types:

(a) A "student," for the purposes of pursuing formal courses, or any combination of courses, research, or teaching, leading to a recognized degree or certificate, in an established school or institution of learning. Upon receipt of a degree or certificate, a student may be granted up to a maximum of 18 months of practical training, provided: (1) The training is needed to round off the academic studies, (2) the training is not available in the student's home country, (3) the training is directly related to the academic program and (4) the training is authorized in writing by the Responsible Officer of the Exchange-Visitor Program involved; or

(b) A "trainee," for the purpose of obtaining on-the-job training with firms, institutions and/or agencies in a specialized field of knowledge or skill for periods not to exceed 18 months; or

(c) A "teacher," for the purpose of teaching in established primary or secondary schools, or established schools offering specialized instruction; or

(d) A "professor," for the purpose of teaching or conducting advanced research, or both, in an established institution of higher learning; or

(e) A "research scholar" or "specialist," for the purpose of undertaking or participating in research; or in demonstrating specialized knowledge or skills; or

(f) An "international visitor," for the purpose of travel, observation, consultation, research, training, sharing, or demonstrating specialized knowledge or skills, or participating in organized people-to-people programs; or

(g) A "professional trainee," for the purpose of pursuing clinical training in the medical and allied fields.

514.23 General limitations of stay.

(a) To insure that exchange visitors remain in the United States only so long as is necessary to satisfy their stated objectives and the intent of the Act, the following general limits on the period of stay of exchange visitors are hereby established. Exceptions to these limitations will be permitted only in unusual circumstances:

(1) Participants.

(i) Students—as long as they pursue substantial scholastic programs leading to recognized degrees or certificates. After receiving degrees or certificates from the U.S. institution, students whom the sponsor recommends for practical training may be permitted to remain for an additional period of up to 18 months.

(ii) Teachers, professors, research scholars, and specialists—3 years.

(iii) International visitors—1 year.

(iv) Professional trainees—2 years for an alien who is a graduate of a medical school pursuing graduate medical education or training in the United States. A 1-year extension may be granted beyond 2 years only if the separately published criteria for aliens who are graduates of a medical school are met (see 514.12(f)).

(v) Graduate nurses—2 years.

(vi) Medical technologists, medical record librarians, medical record technicians, radiologic technicians, nurse anesthetists, and other participants in similar categories—length of the approved training program plus a maximum of 18 months for practical training, not to exceed a total of 3 years.

(vii) Business and industrial trainees—18 months.

(2) *The immediate family.* As long as the participant remains.

(b) The limitations in this section prescribe, as a general rule, the maximum stays of exchange visitors in the categories cited. A participant who is able to complete the stated program objective in less than the maximum lengths of time will be expected to return abroad to comply with the purposes of the Act. These limitations apply regardless of the number of Exchange-Visitor Programs in which the visitor participates. Therefore, transfer from one Exchange-Visitor Program to another will not extend the stay of a participant beyond the limits set for a particular category. These limitations should not be construed as extending or changing in any way the authorized period of stay specified in the official description of an Exchange-Visitor Program.

* Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to USIA Clearance Officer, M/ASP, U.S. Information Agency, 301 4th Street, SW., Washington, DC 20547; and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC 20503.

Appendix C—Appendix to IAP-37**Additional Information for Application for a Training Program**

Note: This appendix will not appear in the Code of Federal Regulations.

Appendix**Appendix to Form IAP-37****Additional Information For Application for Training Program**

[22 CFR § 514.5 and § 514.22(h)(5)]

A. Training Objectives and Activities.

(1) Outline the training program with a brief description of the program's chronology, training methods, and training activities.

(2) Describe what is peculiarly American about the methods or technology to which the trainee will be exposed.

B. Methods of the Training Program.

(1) List the skills or competencies that the trainee should have acquired at the conclusion of the training program. Briefly describe the program methods and activities which will help the trainee obtain these skills or competencies.

(2) Describe any off-site training components to which the trainee will be exposed, e.g., site visits, attendance at conferences or seminars, etc.

(3) List any special equipment that the trainee will likely use upon his/her return to the home country and on which the trainee should be trained as part of the training program. Briefly describe how the trainee will learn to use the equipment.

(4) Justify the utilization of on-the-job training to achieve stated course competencies, i.e. how the on-the-job training will help the trainee learn the previously described competencies and skills.

	Generally describe how and by whom the trainee will be supervised during the course of the program.	(4) State the source and amount of the trainee's stipend, if any.
<i>C. General Program Information.</i>		
(1) English Language Proficiency.		
Describe the sponsor's method of testing the trainee's competence with the English language.		
	(3) Evaluation.	(Please attach separate sheet(s) if more space is needed to answer any of above questions. Attach any other material which may help explain your program.)
	Describe how, by whom and with what frequency the trainee and the training program will be evaluated and the trainee's progress monitored.	
		Appendix D—Update Information on Exchange-Visitor Program Sponsor
		Note: This appendix will not appear in the Code of Federal Regulations.
(2) Supervision.		BILLING CODE 8230-01-M

APPROVED OMB
3116-0011
(7/92)UPDATE OF INFORMATION ON EXCHANGE-VISITOR
PROGRAM SPONSOR

Please amend the United States Information Agency records for Exchange-Visitor Program Number _____

assigned to _____ as follows
(name of program sponsor)

1. () Change the name of the Program Sponsor from the above to _____

2. () Change the address of the Program
Sponsor from:

to:

(city)

(state)

(zip)

(city)

(state)

(zip)

3. () Change the telephone number from _____ to _____

4. () Change the name of the Responsible Officer of the above program from _____
to _____5. a. () Delete the following Alternate
Responsible Officers:5. b. () Add the following Alternate
Responsible Officers:

6. () Send ____ (indicate number) IAP-66 forms.

7. () Send ____ copies of this form.

8. () Send ____ copies of Codes for Educational and Cultural Exchange.

9. () Cancel the above named Exchange Visitor Program.

(signature of responsible officer or alt.)

(date of form)

(title of signing officer)

Instructions

The United States Information Agency records on Exchange-Visitor Sponsors must be up-to-date. From time-to-time, lists of Program Sponsors, their addresses, and names of personnel authorized to sign IAP-66 forms (Responsible Officers and their alternates) are provided to U.S. Consuls and Immigration Officers so that they may verify the validity of IAP-66 forms presented to them. If Program Sponsors do not notify the Agency of changes in name, address, and names of Responsible Officers and Alternate Responsible Officers, it is possible that a U.S. Consul or Immigration Officer might refuse to accept an IAP-66 signed by a person who is not registered with the United States Information Agency as a Responsible Officer or Alternate Responsible Officer.

This Form Should Be Filled Out as Follows

(A) Enter your program number as it appears in the United States Information Agency records, followed by the name of your organization as it is currently recorded. (Do not use Roman Numerals in the Program Number.)

(B) Enter any appropriate changes of address and/or telephone number.

(C) Enter any change in Responsible Officer.

(D) Enter the names of any Alternate Responsible Officers to be deleted.

(E) Enter the names of any Alternate Responsible Officers to be added.

(F) If you wish to receive a supply of IAP-66 forms, indicate the number of forms you wish to receive.

(G) If you need additional copies of this form or the publication *Codes for Educational and Cultural Exchange*, indicate the number.

(H) If you desire, you may request that the Exchange Visitor Program indicated on this form be cancelled. (Cancellation of an Exchange Visitor program by the sponsor will not preclude the establishment of a new program at a later date.)

Send this form to the: Exchange Visitor Facilitative Staff GC/V, United States Information Agency, Washington, DC 20547.

Appendix E—Annual Report

Note: This appendix will not appear in the Code of Federal Regulations.

United States Information Agency**Exchange Visitor Program; Annual Report**

Exchange Visitor Program No. _____ Reporting Year _____
Name of Sponsor _____
Sponsor number _____
Date _____

I. Program Activity

Please provide a brief summary of program activity for reporting period; highlight any programmatic practices you feel may be of use to other exchange sponsors.

II. Reciprocity

Please provide a detailed description of the nature and extent of reciprocal exchange activity conducted in conjunction with your

organization's exchange program. Include the number and categories of exchange visitors entering the United States and the number of United States citizens going abroad and the general purposes of their visits, e.g., to study, to teach etc.

III. Program Growth

Please provide a description of any program expansion and the number of exchange participants you anticipate in the coming year.

IV. Program Transfers

Please provide a list and document identification numbers of all exchange visitors who transferred to or from your program during the reporting year and the program to or from which they transferred.

V. IAP-66 Reconciliation

Please provide the number and document identification numbers, where indicated, of all IAP-66 Forms disbursed to and issued by your organization during the reporting year.

(i) Number of IAP-66 Forms on hand at beginning of reporting year _____

Set forth document identification sequence numbers _____

(ii) Number of IAP-66 forms and sequence numbers received by sponsor during reporting year _____

(iii) Number of IAP-66 forms issued by sponsor to individuals who did not participate in sponsor's exchange program during reporting year _____

(A) For those declining to participate list document identification numbers. (Use an additional sheet if necessary.) _____

(B) For those pending arrival, acceptance or in transit list document identification numbers. (Use an additional sheet if necessary.) _____

(iv) Number and document identification numbers of IAP-66 forms voided or destroyed by sponsor during reporting year. (Use an additional sheet if necessary.) _____

(v) Number and document identification numbers of IAP-66 forms in sponsor's possession at the time of report. (Use an additional sheet if necessary.) _____

[FR Doc. 91-28016 Filed 11-22-91; 8:45 am]

BILLING CODE 9230-01-M

UNITED STATES INFORMATION AGENCY**22 CFR Part 514**

[Rulemaking No. 6]

Training, Exchange Visitor Program

AGENCY: United States Information Agency.

ACTION: Notice of proposed rulemaking.

SUMMARY: By this notice the Agency is proposing regulations governing training programs designated under the Exchange Visitor Program to replace the present regulations which appear at 22 CFR 514.13(c) ("Practical trainees"). The purpose of the proposed regulations is to facilitate enhanced Agency oversight and administration of training exchanges.

DATES: Comments on the proposed rule will be accepted until February 24, 1992. All written communications received on or before the closing date will be considered by the Agency before it takes action on a final rule.

ADDRESS: Please submit five copies of written comments to: Rulemaking No. 6, Merry Lynn, Assistant General Counsel, Office of the General Counsel, room 700, United States Information Agency, 301 Fourth Street, SW., Washington, DC 20547.

FOR FURTHER INFORMATION CONTACT:

Merry Lynn, Assistant General Counsel, Office of the General Counsel, room 700, United States Information Agency, 301 Fourth Street, SW., Washington, DC 20547, (202) 619-6829.

SUPPLEMENTARY INFORMATION: For over forty years, educational and cultural exchange programs have been a vital component of U.S. foreign policy. A cornerstone of United States public diplomacy efforts, educational and cultural exchange programs seek to promote friendly and peaceful relations between the people of the United States and other countries of the world. In passage of the United States Information and Educational Exchange Act of 1948, (Pub. L. No. 80-402, Smith-Mundt Act) and the Mutual Educational and Cultural Exchange Act of 1961, (Pub. L. No. 87-256, Fulbright-Hays Act), Congress provided the umbrella under which educational and cultural exchanges are conducted. These two Acts of Congress direct the Agency, pursuant to its administration of the Exchange Visitor Program, to facilitate and promote exchanges, including training exchange programs. Congress created the J-visa to implement the exchange activities authorized by the Fulbright-Hays Act.

Following the passage of the Smith-Mundt Act in 1948, the Department of State, the Agency's predecessor in implementing exchange programs, promulgated regulations governing educational and cultural exchanges. Among other things, these regulations recited various categories of aliens allowed to participate in exchange visitor programs pursuant to the statutory language of the Act. Among

these categories were "trainee", defined as an alien seeking to enter the United States temporarily in order to participate in an exchange visitor program "for the purpose of obtaining practical training in public administration, industry, medicine, agriculture, or some other specialized field of knowledge or skill. . . ." 22 CFR part 68 (1949).

In 1961, Congress in turn passed the Fulbright-Hays Act, again directing the inclusion of training as a category of exchange participation. Although an integral part of Agency administered exchanges, it was not until 1983 that separate regulations governing training activities utilizing the J-visa were promulgated. 22 CFR 514.13(c) (1983). These regulations have not been amended or revised since first promulgated.

In response to a General Accounting Office (GAO) investigation, discussed below, the Agency has reviewed the legislation and legislative history underlying the Exchange Visitor Program and existing regulations to determine whether such regulations comport with the statutes governing this program. As discussed below, the Agency proposes to amend existing regulations in such a manner that the criticisms raised by the GAO are addressed and distinctions between training and work are obvious and clearly drawn.

The Agency is proposing regulations which address the criticisms of the GAO and clearly distinguish between training and work that is not training. Thus, the Agency proposes that all training conducted under the aegis of the Acts be clearly defined and structured, and on a level appropriate to the trainee's background and experience.

Mindful that any utilization of the J-visa is an exercise of U.S. foreign policy, the Agency will require that all exchange visitor programs contain a provision for reciprocal exchange and for a cultural component, both activities having been specifically enumerated in the language of the Acts. Those matters will be discussed in regulations discussing the General Provisions, which are the subject of a separate rulemaking.

GAO Report

The controversy over the legitimacy of certain activities of foreign nationals in the United States on exchange visitor visas sparked Congressional concern as to the propriety of certain educational and cultural exchange programs administered by the Agency. A GAO investigation and report followed.

The report by GAO, entitled "Inappropriate Uses of Educational and Cultural Exchange Visas," and dated February 16, 1990, (GAO Report) concluded that:

A number of J-visa activities in the practical training and international visitor categories, including summer student travel/work, camp counselor, and au pair activities—some of which have been ongoing for years—do not conform to the original legislative intent concerning educational and cultural exchanges.

GAO Report at 23.

While the words "trainee" and "receiving training" are not expressly defined in either of the educational and cultural exchange Acts, the GAO noted that the existing training sanctioned by the Agency "did not have the same status as the categories mentioned in the statutes and would not generally be considered to have the same educational and cultural value." *Id.* at 16.

The Agency is of the opinion that the vast preponderance of the exchange visitor training programs are conducted well within the legislative authorities created by the Act. However, the GAO found that certain training programs inappropriately "consisted primarily of employment in commercial enterprises with no cultural or educational emphasis placed on the participants' activities. This training involved participants in such capacities as waiters, cooks, hotel workers, and automobile body repairers." *Id.* at 3. It is noted that the GAO Report stated only that "some" training programs consisted primarily of employment in commercial enterprises with no cultural or educational emphasis placed on the participants' activities.

Reports from various consular posts abroad support the above observation by the GAO investigative team. To cite just one anecdotal example from Agency files: In November 1988, three cooks appeared with executed Forms IAP-66 before a United States consular officer in Shanghai and sought exchange visitor visas allowing them to enter the United States in order to take part in an 18-month practical training program in "culinary sciences" in the employment of a Bethesda, Maryland, Chinese restaurant. The consular officer, upon being advised that the three cooks had 32, 18 and 16 years of cooking experience, respectively, refused to issue the visas. He concluded that these three individuals were not entering the United States to take part in a legitimate training program, but were instead being brought to the United States as temporary workers. There are many other examples of inappropriate use of

both the Exchange Visitor Program and the J-visa.

Private Sector Participation

Both the Smith-Mundt Act and the Fulbright-Hays Act contemplate and provide for private sector participation in the educational and cultural exchange matrix. Pursuant to Agency designation as exchange visitor program sponsors, the private sector has for over forty years conducted the lion's share of exchange activity authorized by these Acts.

Congress clearly intended that the private sector was to have a major role in educational and cultural exchange activities. Indeed, when Congress assigned the Agency its mission in 1978, it reemphasized, amongst other things, that the Agency was to "encourage private institutions in the United States to develop their own exchange activities, and provide assistance for those exchange activities which are in the broadest national interest." 22 U.S.C. 1461-1 (1988).

The private sector frequently, but not necessarily always, conducts programs which further the foreign policy objectives of both the Smith-Mundt and Fulbright-Hays Acts. The proposed regulations are drafted to ensure that designated private sector programs promote those exchange activities which are within the intent of the Acts and complementary to United States foreign policy. For example, in addition to other concerns, the Agency will evaluate, in the context of foreign policy, whether the training is available in the trainee's home country and whether an applicant's training program will provide a benefit to the trainee's home country when determining whether to designate an applicant's program.

Distinction Between Work and Training

As noted above, the Agency has been justifiably criticized for allowing the Exchange Visitor Program to be used to circumvent the immigration and labor laws of the United States by allowing foreign workers to use the program under the guise of educational and cultural exchange. This criticism has centered on designated private sector training programs and generated considerable debate concerning the distinction between work, i.e. gainful employment, and legitimate training. Recognizing that training more often than not occurs in a work place setting, the Agency has determined that the distinction between unauthorized gainful employment and authorized training may best be drawn through examination of the components of a

bona fide training program. The requirements for a *bona fide* training program are set forth in § 514.22(f).

As a prerequisite to Agency designation, the Agency proposes that applicants submit a general description of the training plan which sets forth what the training objectives are, the proportion of time that will be devoted to conferences, seminars and classroom instruction, on-the-job training, and any special skills or subjects to which the trainees will be exposed, e.g., computer training. Additionally, the training plan must define the competencies which the trainees will obtain through participation in each segment of the training program. 22 CFR 514.22(h). Applicants need not submit a separate training plan for each trainee. Points to be discussed and included in the general training plan are set forth in the Appendix to the proposed regulations.

The Agency proposes to give priority to those private sector training programs which provide training in "specialty occupations." Those programs devoted to non-specialty occupational training will be closely scrutinized in the designation process and may not be designated unless clearly warranted by foreign policy objectives. This proposal is consistent with the legislation underlying educational and cultural exchange activities, yet is flexible enough to allow the Agency to respond to *ad hoc* foreign policy needs.

The Agency does not necessarily view a specialty occupational trainee as a worthier participant in the Exchange Visitor Program than a non-specialized occupational trainee. The Agency considers the distinction to be significant only because past experience has shown that some of the non-specialty occupational training programs were, in reality, work programs designed to meet the staffing needs of an employer. Thus, the Agency has determined that non-specialty occupational programs require closer examination than was previously undertaken in the past.

The Agency, therefore, proposes to draw a distinction between "specialty occupation" and "non-specialty occupation" as an effort to curtail the use of J-visas for unauthorized work or staffing purposes. The Agency concludes that the potential for inappropriate usage of the J-visa is most pronounced in those areas of productive employment which are generally considered semi-skilled or unskilled in nature. For example, the Agency would not look with favor on an application for designation of a program to train persons in secretarial or clerical skills or in hospital orderly skills. The Agency

will presume that such training would in reality be designed for staffing purposes and, therefore, inconsistent with the Agency's mission. [See § 514.22(b)]

Justification for the distinction between "specialty occupation" and "non-specialty occupation" may be found in both the original regulations governing the Exchange Visitor Program and in the legislative history of the Acts. In 1949, the Department of State permitted "trainee" participants pursuing training in "public administration, industry, medicine, agriculture, or some other specialized field of knowledge or skill. . ." 22 CFR part 68 (1949) (emphasis added). The legislative history of the Smith-Mundt Act refers to the training of meteorologists, agricultural research by the operation of collaborative experiments and research stations, hydroelectric experts, malaria experts, and experts in the fields of economics, business administration, agricultural design and construction, communications, and distribution of electric power. United States Information and Educational Exchange Act of 1948: Hearings on H.R. 3342 Before a Special Subcomm. of the House Comm. on Foreign Affairs, 80th Cong., 1st Sess. 148-50 (1947).

While most of the early exchange visitor training programs fell in specialized areas such as those noted above, the legislative history of the 1961 Fulbright-Hays Act strongly suggests that Congress intended the program to be broadly construed and highly flexible and adaptable to changing needs and conditions. In recognition that non-specialty occupational training can be an important part of our foreign policy, the Agency does not propose to exclude them altogether from the Exchange Visitor Program. Since the passage of the Fulbright-Hays Act, the world has seen a major expansion in non-specialty occupational training and such programs have become an important part of our foreign policy.

For example, the Agency has for many years sanctioned a number of agricultural training programs. Those programs typically involve a mix of skills and experiences, some of which may be considered to be of a specialized nature and some of which may be deemed to be of a non-specialized or less-skilled nature. Nevertheless, the Agency believes that modern American farming techniques are unique and that it is in the foreign policy interests of the United States to share these techniques with trainees from other countries. Therefore, because they meet foreign policy needs the Agency will continue to designate agricultural training programs

even though they may not in all cases fall squarely within the definition of "specialty occupation." Of course, should any agricultural training program proposed for designation prove to be an employment or staffing program, such program will not be designated.

With respect to training programs in other occupational fields not deemed to be in a specialty occupational area, such programs will be subject to close examination by the Agency to determine whether or not they meet foreign policy objectives, whether the training is available in the trainee's home country, and whether the training is in reality designed for staffing purposes.

While the Agency will not require a detailed training plan for each trainee, we anticipate that sponsors engaged in *bona fide* training programs will, in the ordinary course of business, prepare such plans and retain them in their files. The Agency may from time to time request an opportunity to inspect these training plans in order to verify sponsor compliance with Agency regulations.

Sponsor Supervision

In the proposed regulations, the sponsor of the program must be directly responsible for all aspects of the trainee's activities while the trainee is in the United States, including the selection, orientation, training, supervision, and evaluation of the trainee. The purpose of this proposal is to assure that responsibility for the trainee resides in one place. It has always been the policy of the Exchange Visitor Program that sponsors be directly responsible for these aspects of the Program, yet analysis of some programs reveals that this policy has not always been observed. The proposed regulations codify and strengthen this existing long-standing policy.

In order to carry out the actual training set forth in a sponsor's approved training plan, the Agency has determined that utilization of a third party by the sponsor may be appropriate. If the sponsor elects to delegate its responsibility for providing approved training to a third party, the sponsor is nevertheless accountable for ensuring that the third party complies with these regulations. A third party's violation of these regulations shall be imputed to the sponsor; therefore, the sponsor's obligation to monitor, control, and oversee the third party is absolute. Simply put, a third party may act for or in place of the sponsor; however, accountability of the sponsor shall be non-delegable.

When a third party is utilized by the sponsor, the Agency requires evidence

of an express written agreement between the sponsor and the third party. Any such agreement shall specifically recite the third party's obligation to act in accordance with all Agency promulgated regulations applicable to the sponsor. In addition, the sponsor must provide the third party with the training plan to be used to train the trainee, and the sponsor and the third party must retain a copy of the training plan in their respective files for a period of three years.

The Agency will no longer approve an organization as a sponsor of a training program where the organization or its agent abdicates its responsibility to directly train and supervise the trainee. The regulations, as noted, will require that the sponsor retain full responsibility for the conduct of the program. Simply placing a trainee in a third-party training program will not be allowed in the future if the sponsor abdicates accountability for the training and well-being of the trainee.

Proof of Bona Fide Training

Under the proposed regulations, an applicant has two alternatives from which to choose in order to establish to the Agency's satisfaction that its training program is *bona fide* and meets Agency standards. Accreditation of a training program assures the Agency of the *bona fides* of a training program and the Agency encourages the utilization of recognized accrediting agencies. Thus, if the applicant presents the Agency with proof of certification or accreditation of its training program by a recognized accrediting agency, it will be deemed to be *prima facie* evidence that the training program is *bona fide* and meets the standards set forth in § 514.22(f). The applicant will accordingly be relieved of many of its reporting and application requirements under the regulations. This will be, of course, without prejudice to the Agency's right to independently review the proposed program for conformity with regulations. Absent accreditation or certification, applicants must meet all the requirements of § 514.22 (f) and (h) to the Agency's satisfaction. The Agency may consult experts to evaluate any training plan submitted pursuant to this requirement.

Included amongst the exchange visitor programs currently designated by the Agency are flight training programs. The Agency considers flight training to be in an important yet sensitive occupational area which requires that particular attention be given to quality assurance. Additionally, flight training schools require more substantial financial resources than many other types of training programs. Several recent

financial failures by flight training schools suggest that the Agency should monitor more closely the financial condition of these program sponsors in order to ensure that program participants are adequately protected.

For these reasons, the Agency is proposing a requirement that in order to be designated, all flight training programs must be accredited by a nationally recognized accrediting authority. With respect to flight training programs, the Agency will in the future consider only the applications of those programs which have already been accredited or those which have formally commenced the accreditation process. The Agency is mindful that the accreditation process may take as long as one year to be completed. Flight training programs which are conditionally designated subject to completion of the formal accreditation process will be designated for up to twelve months.

The Agency had considered limiting training programs to twelve months. Upon consultation with a number of current sponsors, the Agency decided to keep the duration of training programs to a maximum of eighteen months, as is presently provided for in the regulations. The primary purposes of training under the Exchange Visitor Program are to expose the visitor to uniquely American techniques, methodology, and philosophy in the visitor's field of endeavor and to provide an opportunity for open interchange of ideas between the visitors and Americans. The law envisions that exchange visitors will return to their home country to share with their compatriots their experiences in the United States, including the fruits of their training. While many of the exchange visitor training programs funded by the United States Government are for less than eighteen months in duration, the Agency concludes that many private sector programs may require eighteen months to maximize the benefits to the trainee.

The Agency is inviting comments from the public on the proposed regulations notwithstanding that it is under no legal requirement to do so. The designation of exchange visitor sponsors and administration of the Exchange Visitor Program are foreign affairs functions. The Administrative Procedure Act, 5 U.S.C. § 553(a)(1) (1989), specifically exempts from the rulemaking provisions of the Act a "foreign affairs function of the United States."

In the interest of preserving its valuable working relationship with the exchange community, the Agency is providing a ninety-day period for

written comments on the proposed regulations of training. In order to expedite review of the comments, the Agency requests that interested parties submit five copies of their comments.

The Agency informally circulated a prior draft of the proposed regulations to some members of the exchange community. The Agency received informal comments in response. The Agency reviewed those comments and incorporated some of the suggestions into these proposed regulations. If these parties wish further consideration of their position, or wish to influence the outcome of the final rule, they must submit written comments to the Agency in response to this proposal.

The Agency also intends to schedule one or more public meetings during the comment period in order to receive the views of interested parties. The time, date, and place of such meetings will be published in the *Federal Register*. Such actions may not be deemed a waiver of the foreign affairs exemption extended the Agency pursuant to the terms of the Administrative Procedure Act.

The information collection requirement contained in this regulation will be submitted to the Office of Management and Budget (OMB) for review and approval under the provisions of the Paperwork Reduction Act.

List of Subjects in 22 CFR Part 514

Cultural Exchange Programs.

Dated: November 12, 1991.

Alberto J. Mora,

General Counsel.

In a document published elsewhere in this issue (Rulemaking No. 5), the Agency is proposing to revise 22 CFR part 514. Proposed part 514 would be amended as follows:

PART 514—[AMENDED]

1. The authority citation for part 514 would continue to read as follows:

Authority: 8 U.S.C. 1101(a)(15)(J), 1182, 1258; 22 U.S.C. 1431–1442, 2451–2460; Reorg. Plan No. 2 of 1977; E.O. 12048 of March 27, 1978; USIA Delegation Order No. 85–5 (50 FR 27393).

2. It is proposed that § 514.2 is amended by adding the following definitions:

§ 514.2 Definitions.

* * * * *

On-the-job training means an individual's observation of and participation in given tasks demonstrated by experienced workers

for the purpose of acquiring competency in such tasks.

Specialty occupation means an occupation that requires theoretical and practical application of a body of highly specialized knowledge to perform fully in the stated field of endeavor. It requires completion of a specified course of education, where attainment of such knowledge or its equivalent is the minimum competency requirement recognized in the particular field of endeavor in the United States. Some examples of specialized fields of knowledge are public and business administration, agricultural research, architecture, engineering, computer and physical sciences, accounting, and print and broadcast journalism.

§ 514.13 [Amended]

3. It is proposed that § 514.13(c) be removed.

4. The heading of § 514.22 would be revised, and the text of the section would be added to read as follows:

§ 514.22 Training.

(a) *Introduction.* These regulations govern all exchange visitor programs under which foreign nationals are provided with opportunities for training in specialty occupations in the United States for periods of up to eighteen months. Regulations dealing with training opportunities which may, under certain conditions, be authorized for foreign students who have completed the requirements for degrees at educational institutions in the United States or who are participating in a training program as part of such degree program are found at § 514.23; regulations governing medical trainees are found at § 514.24. When used herein the term "sponsor" shall mean the sponsor of a designated training program, an applicant for designation, or a third party acting on their behalf, in conformity with § 514.22 (d) and (e).

(b) *Purpose of Training.* The primary purpose of training is to enhance the exchange visitor's skills in his or her specialty occupation through participation in a structured training program and to improve the participant's knowledge of American techniques, methodology, and philosophy within the individual's field of endeavor. Such training programs are also designed to enable the exchange visitor trainee to better understand American culture and society and to improve American knowledge of foreign cultures and skills by providing the opportunity for an open interchange of ideas between the exchange visitor

trainees and their American counterparts, both in the United States and, through reciprocity requirements, in foreign countries.

(c) *Designation of Training Programs.* The Agency will limit its designation of training programs to those which provide training in specialty occupations. However, the Agency, in its sole discretion, may designate a non-specialty training program if warranted by foreign policy needs.

(d) *Obligation of Sponsors.*

(1) The sponsor of a designated training program shall comply at all times with the standards set forth at § 514.22(f).

(2) The sponsor may utilize the services of third parties in the conduct of the designated training program pursuant to § 514.22(e). If a third party is utilized, the sponsor and the third party shall execute a written agreement which delineates the respective obligations and duties of the parties, and specifically recites the third party's obligation to act in accordance with these regulations. The sponsor shall provide a copy of such agreement to the Agency upon execution.

(e) *Accountability of Sponsors for Actions of Third Parties.* The sponsor's use of a third party in the conduct of a designated training program does not relieve the sponsor of its obligation to comply, and to ensure the third party's compliance, with all applicable regulations. Any failure on the part of the third party to comply with all applicable regulations will be imputed to the sponsor.

(f) *Standards for Training Programs.*

(1) The Agency will consider the designation of only those training programs which:

(i) Impart skills, knowledge, and competencies to the trainee through a structured mix of activities supportive of the training experience. These may include, for example, classroom training, seminars, rotation through several departments, on-the-job training, and attendance at conferences, as appropriate.

(ii) Provide a schedule, defined objectives, and periodic evaluation of the trainees.

(iii) Provide for continuous and direct supervision of the trainee by the sponsor.

(iv) Have available sufficient plant, equipment, and trained personnel to provide the training specified.

(2) Sponsors shall retain all records pertaining to individual trainees, including training plans and trainee evaluations, for a period of three years.

(g) *Agency Consultation With Experts.* The Agency may consult

experts whenever its examination of a training plan indicates the need for such expertise in making an evaluation.

(h) *Application for Designation of Training Programs.* (1) An applicant for designation as an exchange visitor training program shall demonstrate its ability to comply with both the General Provisions set forth in Subpart A, and the standards for a structured training program set forth in § 514.22(f).

(2) The application shall include a copy of the written agreement between the applicant and a third party, if any, which the sponsor intends to utilize in the conduct of the training program.

(3) If the training program is certified or accredited in accordance with § 514.22(j), the applicant shall include a copy of the certification or accreditation in its application.

(4) The application shall include a certification that:

(i) The applicant will dedicate sufficient physical plant, equipment, and trained personnel to provide the training specified;

(ii) The training program is not designed to recruit and train aliens for employment in the United States;

(iii) The applicant will not fill a position which has the effect of displacing a full-time employee.

(5) The applicant shall also:

(i) Describe in general the structure of the training course and the skill, knowledge, and competencies to be provided to the trainee in each segment of the training program;

(ii) List any skills or subjects to which the trainee will be exposed;

(iii) Justify the utilization of on-the-job training to achieve stated course competencies;

(iv) Estimate the number of hours that will be spent in all training components, such as classroom instruction, conferences or seminars, orientation, and in on-the-job training;

(v) Set forth the source and amount of any stipend, fee, or other consideration to be received by either the trainee or the applicant in the U.S. or elsewhere;

(vi) Describe how the trainee will be supervised and evaluated.

(i) *Selection of Trainees.* (1) Trainees shall be fully qualified to participate successfully in a structured training program at a level appropriate for the individual trainee's career development. However, such training shall not be duplicative of the trainee's prior training and experience.

(2) Trainees must have sufficient knowledge of the English language to enable them to function in an English-speaking environment, unless the training is three months or less and the

trainer provides the training in the trainee's language.

(j) *Accreditation.* Accreditation of a training program shall be *prima facie* evidence of compliance with the provisions set forth above in § 514.22(f) if each segment of the particular training program has been certified or accredited by an accrediting agency which is listed in the current edition of the United States Department of Education's "Nationally Recognized Accrediting Agencies and Associations," or if it has been certified or accredited by a member of the Council of Post-Secondary Accreditation.

(k) *Limitation on duration of stay.* The duration of stay shall correspond to the length of the program set forth in the sponsor's designation. The maximum length of stay in the United States for a trainee shall not exceed 18 months total.

(l) *Financial and program disclosure.* Sponsors shall provide trainees, prior to their arrival in the United States, with:

(1) A written statement which clearly states the stipend, if any, to be paid to the trainee;

(2) The costs and fees for which the trainee will be obligated;

(3) An estimate of living expenses during the duration of the trainee's stay, and;

(4) A summary of the training program which recites the training objectives and all significant components of the program.

(m) *Evaluation.* In order to ensure the quality of the training program, the sponsor shall develop procedures for the on-going evaluation of each training segment. Such evaluation shall include, as a minimum, semi-annual and concluding evaluation reports from the trainee and his or her immediate supervisor, signed by both parties. For training courses of less than nine months duration, evaluation reports are required, at a minimum, at mid-point and upon conclusion of the training course. Evaluation reports shall be kept in the custody of the sponsor for a period of three years and shall be made available to the Agency upon request.

(n) *Flight Training.* The Agency will consider the application for designation of a flight training program if such program complies with the above regulations, and, additionally,

(1) Is, at the time of making said application, a Federal Aviation Administration certificated pilot school pursuant to Title 14, Code of Federal Regulations, part 141; and,

(2) At the time of making said application is accredited as a flight

training program by an accrediting agency which is listed in the current edition of the United States Department of Education's "Nationally Recognized Accrediting Agencies and Associations", or is accredited as a flight training program by a member of the Council on Post-Secondary Accreditation. Duration of the trainee's stay will be granted in accordance with program accreditation, but in no case shall be more than eighteen months;

(3) At the time of making said application has formally commenced the accreditation process with an accrediting agency which is listed in the current edition of the United States Department of Education's "Nationally Recognized Accrediting Agencies and Associations," or with a member of the Council on Post-Secondary Accreditation. If the application for designation is approved, such designation shall be for up to twelve months duration, with continued designation thereafter conditioned upon completion of the accreditation process.

[FR Doc. 91-27576 Filed 11-22-91; 8:45 am]

BILLING CODE 8230-01-M

Federal Register

Monday
November 25, 1991

Part IV

Department of the Interior

Bureau of Indian Affairs

25 CFR Part 83

Procedures for Establishing That an
American Indian Group Exists as an
Indian Tribe; Notice of Public Meeting on
Proposed Rule

DEPARTMENT OF THE INTERIOR

Bureau of Indian Affairs

25 CFR Part 83

Procedures for Establishing That an American Indian Group Exists as an Indian Tribe

November 18, 1991.

AGENCY: Bureau of Indian Affairs, Interior.**ACTION:** Notice of public meetings on proposed rule.

SUMMARY: On September 18, 1991, (56 FR 47320) the Department of the Interior published proposed revisions to 25 CFR part 83 to improve and clarify the system for considering petitions from Indian groups seeking acknowledgment as Indian tribes. As announced, public comments on the proposed rule will be accepted until December 17, 1991. This document provides notice of the dates, times and locations of nine public meetings to receive oral comments on the proposed rule in order to provide the public the widest opportunity to comment on these proposed revisions to 25 CFR part 83.

DATES: The meetings are scheduled at the following time and locations:

1. December 5, 1991, 10 a.m. to 4 p.m., Ramada Hotel, 100 E. River Dr., Hartford, CT.
2. December 10, 1991, 10 a.m. to 4 p.m., Radisson Hotel, 2040 Airport Dr., Green Bay, WI.
3. December 10, 1991, 10 a.m. to 4 p.m., Saddleback Inn, 4300 Southwest 3rd, Oklahoma City, OK.
4. December 11, 1991, 10 a.m. to 4 p.m., Quality Hotel Four Seasons, 2500 Carlisle NE., Albuquerque, NM.
5. December 11, 1991, 1 p.m. to 5 p.m., Town and Country Hotel, 500 Hotel Circle North, San Diego, CA.
6. December 12, 1991, 7 p.m. to 10 p.m., Beverly Garland Hotel, 1780 Tribute Road, Sacramento, CA.
7. December 12, 1991, 10 a.m. to 4 p.m., Holiday Inn North, 3815 N. Tryon St., Charlotte, NC.
8. December 13, 1991, 10 a.m. to 4 p.m., Comfort Inn, 2445 S. Acadian Thruway, Baton Rouge, LA.
9. December 13, 1991, 10 a.m. to 4 p.m., Everett, 101 128th St., SW., Everett, WA.

FOR FURTHER INFORMATION CONTACT: Holly Reckord, Acting Chief, Branch of Acknowledgment and Research, Bureau of Indian Affairs, 1849 C Street, NW., Mail Stop 2612-MIB, Washington, DC 20240, (202) 208-3592.

SUPPLEMENTARY INFORMATION: Regulations to govern the review of petitions from groups seeking acknowledgment as Indian tribes first became effective October 2, 1978. Since the first publication and application of the regulations, numerous issues have been raised concerning the interpretation of some of the provisions in these regulations. Consequently, the Department proposed to amend the regulations with the publication of a proposed rule on September 18, 1991 (56 FR 47320). The proposed revisions will clarify the procedures for petitioners, eliminate some of the problems that have arisen which were not covered by the existing regulations, and improve the quality of future petitions.

It is the policy of the Department of the Interior to afford the public an opportunity to participate in the rulemaking process whenever practicable. Due to the broad public interest in the acknowledgment process shown by unrecognized Indian groups, recognized Indian tribes, the Congress, and other members of the public, the Department has made the determination to hold public meetings on the proposed revisions to 25 CFR part 83 to assure

more meaningful and extensive public participation in the rulemaking process.

The meetings are open to the public. Interested persons may make oral and written statements. Due to the limited amount of time available and the desire to hear a range of views, each speaker will be allocated five to ten minutes for an oral statement, depending on the number of people who wish to make presentations. Organizations wishing to present oral statements will be limited to one speaker. Requests to present oral statements at the meetings must be received by Holly Reckord, Acting Branch Chief, Branch of Acknowledgment and Research, Bureau of Indian Affairs, 1849 C Street NW., Mail Stop 2612-MIB, Washington, DC 20240 no later than December 2, 1991. An agenda showing the schedule of speakers will be made after requests are received from persons who wish to present oral statements. Reservations for the agenda will be on a first-come, first-served basis and will be limited by the duration of the meetings. Copies of the agenda will be available at the meetings. If time allows, individuals may also sign up to present comments during a one-hour registration period preceding the oral presentations. Written comments on the proposed rule are strongly encouraged, since verbatim transcripts of the meetings will not be made.

Copies of the proposed rule may be obtained by calling Holly Reckord, Acting Branch Chief, Branch of Acknowledgment and Research, Bureau of Indian Affairs, 1849 C Street NW., Mail Stop 2612-MIB, Washington, DC 20240, (202) 208-3592.

Patrick A. Hayes,
Acting Assistant Secretary—Indian Affairs.
[FR Doc. 91-28256 Filed 11-22-91; 8:45 am]

BILLING CODE 4310-02-M

Executive Order Federal Reserve

**Monday
November 25, 1991**

Part V

The President

**Executive Order 12782—Amending
Executive Order No. 12594**

Monday, November 22, 1964

Part V

The President

Executive Order 12782—Amending
Executive Order No. 12544

Presidential Documents

Title 3—

Executive Order 12782 of November 21, 1991

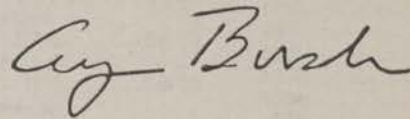
The President

Amending Executive Order No. 12594

By the authority vested in me as President by the Constitution and the laws of the United States of America, and in order to amend Executive Order No. 12594, it is hereby ordered as follows:

Section 1. Section 1 of Executive Order No. 12594 is amended to read as follows: "Awards shall be given for the purpose of recognizing outstanding voluntary contributions by individuals and organizations toward helping others in our society, and for the purpose of demonstrating to all Americans what can be accomplished through voluntary action. Awards shall be named, designed, and presented as determined by the President upon the recommendation of the White House Office of National Service."

Sec. 2. Section 2 of Executive Order No. 12594 is amended to read as follows: "The awards may be presented by the President to recipients in categories to be determined by the President or the Director of the White House Office of National Service. The selection process shall be administered by the White House Office of National Service in coordination with the ACTION agency and other appropriate entities. The President may select for the awards any person recommended to the President or any person selected by the President upon his own initiative."



THE WHITE HOUSE,
November 21, 1991.

[FR Doc. 91-28446

Filed 11-22-91; 10:12 am]

Billing code 3195-01-M

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Monday, November 25, 1991

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CFR CHECKLIST

This checklist, prepared by the Office of the Federal Register, is published weekly. It is arranged in the order of CFR titles, stock numbers, prices, and revision dates.

An asterisk (*) precedes each entry that has been issued since last week and which is now available for sale at the Government Printing Office.

A checklist of current CFR volumes comprising a complete CFR set, also appears in the latest issue of the LSA (List of CFR Sections Affected), which is revised monthly.

The annual rate for subscription to all revised volumes is \$620.00 domestic, \$155.00 additional for foreign mailing.

Order from Superintendent of Documents, Government Printing Office, Washington, DC 20402. Charge orders (VISA, MasterCard, or GPO Deposit Account) may be telephoned to the GPO order desk at (202) 783-3238 from 8:00 a.m. to 4:00 p.m. eastern time, Monday-Friday (except holidays).

Title	Stock Number	Price	Revision Date
1, 2 (2 Reserved)	(869-013-00001-3)	\$12.00	Jan. 1, 1991
3 (1990 Compilation and Parts 100 and 101)	(869-013-00002-1)	14.00	Jan. 1, 1991
4	(869-013-00003-0)	15.00	Jan. 1, 1991
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700-1199	(869-013-00005-6)	13.00	Jan. 1, 1991
1200-End, 6 (6 Reserved)	(869-013-00006-4)	18.00	Jan. 1, 1991
7 Parts:			
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27-45	(869-013-00008-1)	12.00	Jan. 1, 1991
46-51	(869-013-00009-9)	17.00	Jan. 1, 1991
52	(869-013-00010-2)	24.00	Jan. 1, 1991
53-209	(869-013-00011-1)	18.00	Jan. 1, 1991
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2000-End	(869-013-00025-1)	10.00	Jan. 1, 1991
8	(869-013-00026-9)	14.00	Jan. 1, 1991
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500-End	(869-013-00033-1)	27.00	Jan. 1, 1991
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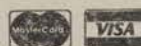


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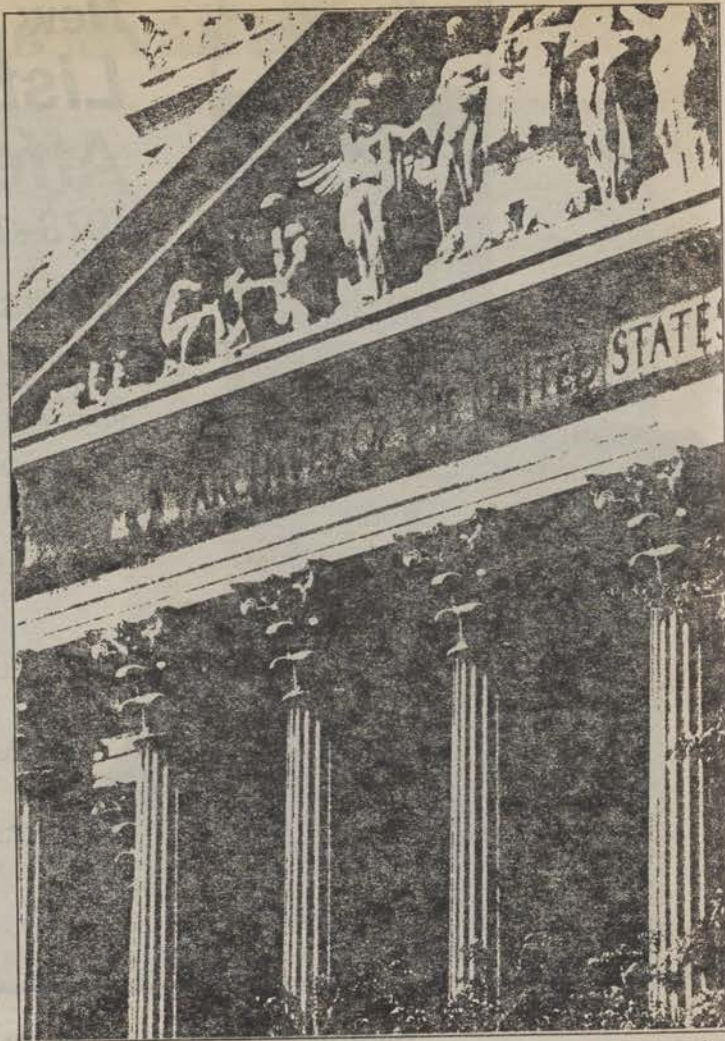
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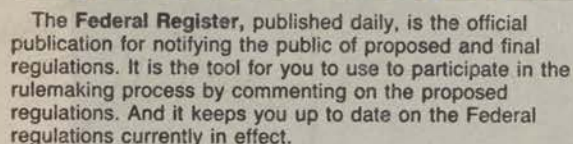
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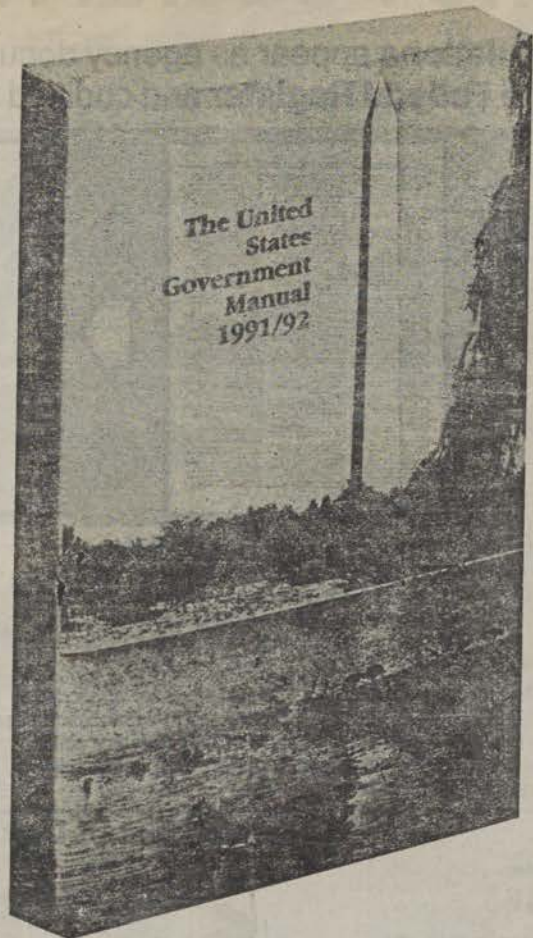
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